Initial Asha Provider

Confidential Patient Information

Today's Date ________________

Personal Information

Affirmed Name ____

Legal Name (if different than above) ____

Age ________ Date of Birth ________________ Pronoun? He/Him She/Her They/Them Other:____

Home address ________________ City ________________ State ________ Zip ________

Home phone # ________________ Email ________________

Occupation ________________ Employer ________________

Emergency Contact: ________________ Phone # ________________ Relationship: ________________

Person responsible for this account ________________ Relationship to patient ________________

Phone # ________________ Address (if different from above) ________________

Insurance Information

Type of policy: ( ) Health Insurance ( ) Auto ( ) Worker's Comp

Name on Medical Records ________________ Sex on Medical Record? Female Male

Name of insured ________________ Relationship to patient ________________

Insurance company name ________________ Insurance Phone # ________________

MEMBER ID# ________________ GROUP or CLAIM # ________________

Policy Holder's Name ________________ Date of Birth ________________

FINANCIAL POLICY – I understand that all billing and accrued balances are ultimately my responsibility and that I will pay these amounts in a timely fashion. There will be a charge for returned checks. Appointment cancellations require advanced notice. Voicemail is available 24 hours a day, 7 days a week and I will be charged the full cost of a visit for any missed appointment without 24-hour notice. If I arrive late I may be asked to reschedule.

Client/Patient NAME________________________________ **Date of Birth**________________________

(Print Name)

Client/Patient signature__________________________ ***Date***____________________

Office Policy Regarding Fees and Payments

1. Private Pay – Full payment is expected at time of each visit. We accept cash, check or MC/Visa/AMEX. If payment is not received at the time of your visit, you will not be eligible for a TOS fee. Labs, supplies and supplements are excluded from this fee. No insurance will be billed if this option is selected.

2. Insurance - For patients who have private health plans covering our services: We require your co-payment at the time of service, per your insurance policy. Insurance coverage is **NOT** a guarantee of payment and you are fully responsible for any fee your insurance does not cover, and for checking your benefits and confirming coverage for all services.

3. Personal Injury/Car Accidents –As a courtesy, we will bill and collect from your car insurance company, however if your insurance company does not pay your balance in full, you are responsible for any unpaid portion and you can recover any monies paid at the time of settlement.

4. Worker's Compensation – If you have been injured on the job, you are required by law to report to your employer first and open a claim. The first provider you see following your injury will be considered your 'primary provider' for this case. *If we are not your primary provider on the case, it will require a referral from that provider.* If a denial occurs, you will be fully responsible for the balance of your account.

Continued on reverse →

The NOTICE OF PRIVACY PRACTICES is attached to your clipboard. If you don't see it, please ask the front desk for a copy of it so that you may read it before you sign this page.
I have read the notice of privacy practices. I have read and understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications.

_______________________________________ _______________________________________
(Authorized Signature) (Date Signed)

_______________________________________ _______________________________________
(Print Name) (Patient Name – if signing as a parent or legal guardian)

Informed consent for routine/referral clinic services

(excludes counseling, psychotherapy, naturopathy) *Please initial and date the following consents for services planned/received.*

______**CONSENT TO ROUTINE MASSAGE SERVICES:** I consent to the services to be rendered during this visit on an outpatient basis by any licensed massage therapists who now or in the future treat me while employed by, working or associated with or serving as back-up for the massage therapist named above. I understand and am informed that, in the practice of massage therapy there are some risks to treatment, including but not limited to sore muscles and joints, increased risk of emboli from varicose veins, and increased blood pressure from hypertension. I do not expect the massage therapist to be able to anticipate and explain all risks and complications, and I wish to rely on the massage therapist to exercise judgment during the course of the procedure which the massage therapist feels at the time, and based upon the facts then known, is in my best interest. I understand that no guarantee has been made to me as to the result or cures that may be obtained from treatment in this clinic. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I may seek treatment.

________**CONSENT TO ROUTINE ACUPUNCTURE SERVICES:** I consent to the services to be rendered during this visit on an outpatient basis by Toshio Omura-Long LAc.,and/or other licensed acupuncturists who now or in the future treat me while employed by, working for or associated with or serving as back-up for the acupuncturists named above. I understand and am informed that, as in the practice of medicine, in the practice of acupuncture, there are some risks including but not limited to bruising, bleeding, blistering, pneumothorax, or fainting. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, and is in my best interests. I understand that no guarantee has been made to me as to the result or cures that may be obtained from examination or treatment in this clinic. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I may seek treatment.

All practitioners of Asha Integrative Wellness are affiliated with each other to combine their skills in the treatment of patient maladies. All Practitioners are legally independent health care practices. They are not affiliated to each other by tax identification or liability. Asha Wellness Center / Pro Chiropractic LLC is not responsible for the business practices or treatments by any affiliated practitioners. All Affiliated business are not responsible for the business practices or treatments by any affiliated practitioners.

CONSENT TO TREATMENT – I, OR MY REPRESENTATIVE, HAVE READ, FULLY UNDERSTAND AND AGREE TO THE ABOVE STATEMENTS.

____
Signature of Patient Date

FOR MINOR PATIENT/ PATIENT UNDER GUARDIANSHIP

Patient is __________ years of age OR unable to sign because: ____

_____________________________ ____________ _______________________________
Parent/ Guardian Signature Date Relationship to patient

Payment Type: MM-INS___ Patient Options___ PIP___WC___DSCT___ FH___