



Patient Information

 PATIENT FIRST NAME MI PATIENT LAST NAME

 STREET ADDRESS CITY STATE ZIP

 HOME PHONE CELL PHONE EMAIL ADDRESS

 BIRTH DATE AGE SOCIAL SECURITY # EMPLOYER

How were you referred to us? _____

Emergency Contact Check box if we can communicate your health information with this person

 FIRST NAME LAST NAME CELL PHONE

If patient is a minor or under care of a legal guardian:

 PARENT / GUARDIAN FIRST NAME PARENT / GUARDIAN LAST NAME RELATIONSHIP

Innovative Health & Wellness Center Financial Policy

Thank you for choosing Innovative Health & Wellness Center as your health care provider. In an effort to control health costs, our office has developed the following financial policy effective January 1, 2008. Please read and sign the statement below as an indicator you understand and agree to comply with our financial policy.

- All payments must be paid in full at the time of service.
- A check is returned for "non-sufficient funds" will be charged a \$25 reprocessing fee in addition to any fee charged to us by the bank.
- **All missed office visits or appointments canceled less than 24 hours prior will be charged the full price of the office visit (\$150).**
- After a missed office visit, a non-refundable credit card payment for the full office visit is required in advance in order to schedule a new appointment.

 PATIENT / GUARDIAN SIGNATURE

 DATE