Innovative Health & Wellness

Patient Information

PATIENT FIRST NAME _____ MI _____ PATIENT LAST NAME _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ EMAIL ADDRESS _____

BIRTH DATE _____ AGE _____ 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.
- **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.
- 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.

PATIENT / GUARDIAN SIGNATURE _____ DATE _____