Southwest Integrative Medicine
4045 East Bell Road, Suite 107
Phoenix, AZ 85032
1 877 655 7869 Tel
602 493 2399 Fax

Patient Information

Last Name: _____ First Name: _____ Middle Name: _____

Preferred Name:_____ Other name(s) that records may be kept under: _____

Date of Birth: _____ Gender:_____ SS#: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Email Address:_____

Home Ph:(_____)_____ Work Ph:(_____)_____ Cell Ph:(_____)_____

May we leave confidential voice-mail messages for you at any of the above numbers? ❍ No ❍ Yes (specify): **❍ Home ❍ Work ❍ Cell**

Employer/School: _____

Mother's Name (minors only): _____ Father's Name (minors only): _____

Emergency Contact: _____ Relationship to Emergency Contact: _____

Contact's Phone #1: (_____)_____ ❍ Home ❍ Work ❍ Cell

This section must be completed if someone other than the patient is financially responsible for the patient's account.

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: (_____)_____

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient and that I am subject to all financial terms listed below.

X _____ _____

Guarantor's Signature **Date**

Terms of Admission

Financial Terms: I understand that if I am providing insurance billing information that I am responsible for all charges whether or not they are covered by my insurance. I understand that finance charges will begin accruing on accounts that are 60 days past due for payment at a rate of 2.5% per month. I further understand that excessively overdue accounts will be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that any guarantor listed above is subject to the same financial terms as outlined in this paragraph and that my payment history, account balance and due dates may be disclosed to the guarantor for the purposes of securing payment. I understand that the guarantor, if someone other than myself, is not authorized to receive my medical information unless expressly authorized by me in writing.

Notice of 24 Hour Cancellation Policy: Should you require canceling a scheduled appointment we require 24 hours notice of this cancellation. In the event we don't receive 24 hours, you may be charged 50% of the scheduled appointment fee.

Privacy Terms: We keep a record of the healthcare services we provide you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the record we keep. Moreover, if you believe that information in your record is inaccurate, you may also request that we correct or amend that record. We will not disclose your medical information to others unless you direct us to do so or applicable laws authorize or compel us to do so. Southwest Integrative Medicine is required to provide you with a copy of its Notice of Privacy Practices and to obtain written acknowledgement that you have received it. The notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning the management of your healthcare information at our clinic, wish to inquire about your rights or if you wish schedule an appointment to view your medical record, please call our medical records office at (480) 285-9794.

I hereby acknowledge that I have received a copy of Southwest Integrative Medicine's Notice of Privacy Practices. Should I refuse or fail to sign this form, I acknowledge that Southwest Integrative Medicine has made a good faith effort to obtain my acknowledgement.

X _____ _____

Patient's Signature Date

X _____ _____

Guardian/Representative's Signature Date

_____

Relationship to Patient/Representative Authority