PATIENT INFORMATION:

SSN: _____-____-_____

_____	_____	_____	_____	M F
Last Name	***First Name***	***Middle***	***Date of Birth***	***Gender***

_____	_____	_____	_____	_____
Address	***Apt#***	***City***	***State***	***Zip Code***

_____	_____
Phone Number	***Email Address***

_____	_____
****If you were referred by someone, who can we thank?***	***Would you like to receive text message reminders for your appointments?***

Pharmacy Information:

Pharmacy Name:_____ ***Phone:***_____

Pharmacy Address: _____ ***City:***_____

Zip Code: _____ ***Cross Streets:*** _____

Insurance Information

Primary Insured's name & Date of Birth: _____ _____/_____/_____

*Primary Insured's Employer Name & Address:*_____

Patient's relationship to Primary Insured: self _____, spouse: _____, child: _____

Secondary Insured's name & Date of Birth: _____ _____/_____/_____

Secondary Insured's Employer Name & Address _____

Patient's relationship to Primary Insured: self _____, spouse: _____, child: _____

Acknowledgement of Notice of Privacy and HIPPAA Notice of Privacy Practice

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of care and services at this practice. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this practice, whether made by practice personnel or your personal provider. By signing this document, I acknowledge that I have read and understand the Notice of Privacy Practices and the HIPAA Privacy Act practices. If you have any questions about this notice, please contact the Privacy Officer/Office Manager. Due to patient privacy laws no photography or electronic recordings are permitted in the clinical area.

Release of Medical Information and Authorization for Treatment

I authorize the release of any medical information to process a claim and further authorize payment of insurance benefits directly to Freedom Total Wellness or its affiliates. To provide for a continuity of care, I authorize the release of medical information to physicians who are participating in my care. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize Freedom Total Wellness and or its affiliates to perform procedures and treatment including the administration of medical and local anesthetics along with other surgical and medical procedures that may be necessary. I hereby grant permission to Freedom Total Wellness and or its affiliates to release any pertinent information to my insurance company upon request, and I also authorize payments to be made on my behalf directly to Freedom Total Wellness and or its affiliates. A photocopy of this authorization shall be considered as effective and valid as original.

Acknowledgement of Receipt of Financial Policy

I acknowledge that I have received the financial policy and the assignment of benefits and rights to pursue ERISA. I understand the policies and agree to abide by their guidelines. In addition, I acknowledge receipt of the HIP AA notice, release of Medical information and agree to consent of treatment as listed above.

_____	_____
Signature	***Date***

10/21/2019