Renovation Health & Wellness Patient Registration Form

Account #	_____ New Patient _____ Existing Patient
Date	* Existing Patient: Revise all information that has changed since your last visit.

Patient's First Name	MI	Last	
Social Security #	Birthdate		Age
Marital Status	Sex		
Address			
City	State	Zip Code	
Home Phone	Mobile Phone		

Patient's Employer's Name	Employer's Address
Work or Business Phone #	Email Address

Pharmacy of Choice	Pharmacy Phone #	
Pharmacy Address		
City	State	Zip Code

Do you have a durable power of attorney for healthcare?

Do you have a living will?

* If yes, please provide a copy of the above document(s) to the office for your medical record.

Person Responsible for Payment of Services (If Individual Other than the Patient)

Patient's First Name	MI	Last	
Social Security #	Birthdate		Age
Address			
City	State	Zip Code	
Home Phone	Mobile Phone		
Patient's Employer's Name	Employer's Address		
Work or Business Phone #			

Emergency Contact Outside of the Household

Name	Relationship	
Home Phone	Mobile Phone	

Insurance Information			
		Secondary Insurance	
Insurance Name	Effective Date	Insurance Name	Effective Date
Claims Address		Claims Address	
Subscriber ID Number	Group Number	Subscriber ID Number	Group Number
Subscriber Name and Address		Subscriber Name and Address	
Subscriber Birthdate	Subscriber SS#	Subscriber Birthdate	Subscriber SS#
Employer Name, Address, and Phone Number		Employer Name, Address, and Phone Number	

The Patient or Guarantor is responsible for payment in full of all services rendered by the nurse practitioner or employees of Renovation Health and Wellness, LLC. Payment is expected at the time of service unless other arrangements are made in advance. Failure to cancel 24 hours prior to a scheduled appointment will result in a $25.00 no show fee billed to your account.

Authorization, Assignment, and Responsibility of Account

I hereby authorize Renovation Health and Wellness, LLC to release the above insurance companies and/or carriers any medical or other information needed for claims reimbursement. I hereby assign, transfer, and set over to Renovation Health and Wellness, LLC all of my rights, title and interest to medical reimbursement benefits under my insurance policy with the above documented insurance companies. I hereby acknowledge and accept responsibility for payment in full of all services rendered to me by Renovation Health and Wellness, LLC.

Patient Consent for Medical Treatment

I, the undersigned, am the patient, or the patient's duly authorized representative, and do hereby voluntarily consent to and authorize medical care and treatment by Renovation Health and Wellness, LLC through its individual healthcare providers, employees, and/or agents. This care and treatment encompasses all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the healthcare provider and provided by Renovation Health and Wellness.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations performed by the nurse practioner or employees of Renovation Health and Wellness, LLC.
I acknowledge that I have received a copy of Renovation Health and Wellness's Notice of Privacy Practices and I understand that the notice is also posted at their location where services are provided and on the Internet at www.renovationhealth.com.

To protect against the transmission of blood-borne diseases such as Hepatitis B and Acquired Immune Deficiency Syndrome, I understand that it may be necessary to test my blood for certain diseases while I am a patient of Renovation Health and Wellness. I understand and consent that my blood, as well as the blood of any person accidentally exposed to my blood, will be tested. I further understand that my blood will not be tested for these diseases unless ordered by my physician and that the results of all tests will be kept confidential.

I have read this form, or had it read to me, and I certify that I fully understand and accept its contents unless noted.

_____ _____

Date Signature of Patient/Guardian/Power of Attorney

_____ _____

Date Signature of Witness