

DYNAMIC HEALTH INSTITUTE

REGISTRATION - PLEASE PRINT AND COMPLETE ALL INFORMATION

Name _____ SS# _____ Today's Date ___/___/___
Date of Birth _____ Age _____ Driver's Lic # _____
Guardian (if under 18) _____ Email Address _____
Marital Status (circle): S M D W Sep Spouse's Name _____
Mailing Address _____ City _____ State _____ Zip _____
Street Address (if different) _____ City _____ State _____ Zip _____
Telephone: Home _____ Work _____ Cell _____
Primary Care Doctor: _____ City _____ State _____ Phone _____
Emergency Contact _____ Phone _____ Relationship _____
Who referred you to our practice (so we can thank them) or how did you learn about us? _____

EMPLOYER INFORMATION

Employment: ___ Full ___ Part-time ___ Not working ___ Retired
Employer Name _____ Phone _____ Occupation _____
Employer Address _____ City _____ State _____ Zip _____

INSURANCE INFORMATION

Insurance: Yes / No (circle one) if yes please have cards available for us to copy and complete below.

PRIMARY INSURANCE _____ ID# _____ Group# _____ Eff Date ___/___/___
Policy Holder Name _____ SS# _____ Relationship _____ D.O.B. ___/___/___
Policy Holder Place of Employment _____ City _____ State _____ Zip _____
SECONDARY INSURANCE _____ ID# _____ Group# _____ Eff Date ___/___/___
Policy Holder Name _____ SS# _____ Relationship _____ D.O.B. ___/___/___
Policy Holder Place of Employment _____ City _____ State _____ Zip _____

COMPLETE BELOW IF PERSONAL INJURY, CAR ACCIDENT, OR WORK INJURY

Injury Type: ___ Work ___ Auto ___ Home ___ Sports Other _____
Attorney (if applicable) _____ Phone _____ City _____ State _____
Insurance _____ Injury Date _____ Policy # _____
Claim Mailing Address _____ Contact Person _____ Phone _____

AUTHORIZATION TO RELEASE INFORMATION & ASSIGN BENEFITS

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me.

Furthermore, I understand that Dynamic Health Institute, Inc. will prepare the necessary reports and forms to assist me in making collection from the insurance company. I authorize the release of any medical information necessary to process my insurance claims. I permit a copy of the authorization to be used in place of the original. I further authorize Dynamic Health Institute to apply for benefits on my behalf for covered services rendered by the staff. I request that any payments from my insurance company be made directly to Dynamic Health Institute knowing the amount will be credited to my account on receipt. I certify that the information I have reported with regard to my insurance coverage is correct. This authorization may be revoked by either me or my insurance company at any time by written request.

Signature _____ Date _____
Patient (or Parent/Guardian)

AGREEMENT OF PAYMENT RESPONSIBILITY

I understand that the fees and charges are based on the cost of doing business. I clearly understand and agree that while insurance claims may be submitted as a courtesy by the staff of Dynamic Health Institute on my behalf, all services are charged as "fee for service" and I am personally and ultimately responsible for all costs incurred as a result of my receiving treatment in this office.

I hereby authorize Dynamic Health Institute, Inc. to treat my condition as is deemed appropriate. I also agree I am responsible for all bills incurred at this office.

Credit Card on file: Visa Mastercard American Express

Name on Card _____

Card Number: _____ Exp Date: _____ CVV _____

Signature _____ Date _____
Patient (or Parent/Guardian)

Consent to treat a Minor: _____

Guardian or Spouses Signature Authorizing Care: _____

AGREEMENT OF OFFICE POLICIES

Office Hours – Appointments

Office Hours are by appointment. Every effort will be made to give you an appointment at the earliest convenience. If you have an urgent problem, we will attempt to see you as soon as possible during normal business hours. If you have an emergency you will need to access urgent care or emergency room facilities.

Cancellations and Missed Appointments

If you can not make your scheduled appointment, please give us the courtesy of at least 24 hours notice so that another patient may have the opportunity to see the doctor. Arriving for your appointment a few minutes early will help ensure that you and other patients are seen in a timely fashion.

If you are more than 15 minutes late for your scheduled appointment, your appointment may be rescheduled. Exceptions are made for emergencies.

Our staff is committed to spending enough time with you to listen to your history and perform a thorough exam. We schedule NEW patients for 40 - 50 minutes visits and follow up visits for 20 minutes. This limits the number of patients we can see per day. Because of our commitment to quality care for you and our other patients, and the increasing trend of the general public to skip appointments without giving notice, it is necessary for us to charge for missed visits – no shows.

Missed visits – no shows are defined as failing to give us 24 hour notice of your inability to make a scheduled appointment.

Missed visits will be charged a fee equivalent to half of the planned treatment visit. \$25 of that fee will be donated to Rachel's House, a shelter for battered women.

Patients who miss three scheduled appointments, without the courtesy of notifying our office at least 24 hours in advance each time, will be released from the practice.

Use of Email Address

With my consent Dynamic Health Institute may on occasion use my email address to communicate general health information, office information, and/or patient referral program information to me. The use will be infrequent/light – pertinent to me as a patient of the clinic. My email address will not be given to any other third parties.

Yes / No (circle one)

Consent Waiver

With my consent, Dynamic Health Institute may call my home or other designated location and leave a message on voice mail or in person, or may email to my home or other designated location any items that assist in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items, and any call pertaining to my clinical care.

Exceptions to consent: Yes / No (circle one) if yes, please indicate here:

I, the undersigned, understand, have read and agree to the above office policies.

Signature _____ Date _____
Patient (or Parent/Guardian)