Anthony Von der Muhll, L.Ac., DNBAO
Board Certified, Acupuncture Orthopedics
303 Potrero St. #42-306, Santa Cruz, CA 95060
Ph 831-459-6762 ☯ Fax 831-470-2739
www.ihcsc.com

Integrative Health Care

Acupuncture ☯ Therapeutic Exercise
Acupressure & Massage Therapy

PATIENT INFORMATION

Patient Name ______________________ Age ________ DOB ______________ Sex ___

Address ______________________ City ______________________ ZIP ________

Home Phone ______________________ Work Phone ______________________

Cell Phone ______________________ Email ______________________

For messages and reminders, please let us know how you would like to be contacted:

Home phone: Yes No Work phone: Yes No
Cell phone: Yes No E-mail: Yes No

Marital Status: □Married □Partnered □Single □Widowed □Divorced □Separated

Employer ______________________ Address ______________________

Employer Phone ____________ Occupation ______________________ How long? ________

Referring Physician ______________________ Phone number ______________

Primary Physician *(if different)* ______________________ Phone number ______________

HEALTH INSURANCE INFORMATION

Insurance Co. ______________________ Member ID# ______________________

Insurance Co. Address ______________________ Insurance Phone ______________

PRIMARY INSURED'S INFORMATION (if different from patient's)

Primary Insured's Name ______________________ Primary Insured's date-of-birth ________

Primary Insured's Address ______________________ Primary Insured's Phone # ________

Primary insured's relationship to patient ______________________ Primary Insured's ID#: ______________

EMERGENCY CONTACT INFORMATION

Name ______________________ Relationship ______________________

Home Ph # ______________________ Work/mobile ph # ______________________

PLEASE COMPLETE ON REVERSE

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TERMS OF ADMISSION TO CARE

Please initial and sign below to indicate that you have read and understood each section.

PATIENT INFORMATION

- ☐ I certify that the information given above by me is correct.
- ☐ I have received Integrative Health Care's *Notice of Privacy Practices* regarding my health information (on reception desk clipboard). I authorize release of any information necessary to coordinate medical care, including disclosure to other health care professionals for the purpose of evaluating my health, diagnosing medical conditions, and providing treatment, and to secure payment for services rendered.

FINANCIAL POLICIES

- ☐ I assign any and all insurance benefits to Anthony Von der Muhll, L.Ac., dba Integrative Health Care. **If my insurance carrier sends payments to me, I agree to send or bring those payments directly to this office upon receipt.**
- ☐ **I understand that all services rendered by this office are charged to me, and that I am personally financially responsible for all charges, regardless of insurance coverage**.
- ☐ **I have been advised to verify my benefits directly with my insurer.** I have been informed that fees for treatment may not be covered by insurance.
- ☐ **I understand that Integrative Health Care (IHC) verifies insurance benefits and bills insurance as a *courtesy* to patients, and that IHC is not financially responsible for benefits verification, nor for collections from insurers.** Claims submitted by IHC and initially rejected by insurers will be re-billed a second time, after which unpaid claims will be billed directly to patients.
- ☐ I understand that a $20 fee will be assessed per bounced check.
- ☐ If my account is referred to a collections agency, that I agree to pay reasonable collections expenses estimated at a minimum of $40, in addition to my full outstanding balance.
- ☐ I understand that if I suspend or terminate my care at any time, my portion of all charges for professional services is immediately due and payable to this office.

LATE CANCELLATIONS/MISSED APPOINTMENTS

- ☐ **I understand that IF I DO NOT PROVIDE MORE THAN 24 HOURS ADVANCE NOTICE of appointment cancellation, or fail to show for a scheduled appointment, I WILL BE CHARGED $35 FOR A MISSED APPOINTMENT.** I am aware that insurance does not generally pay for missed appointments, and that exception to missed appointment charges is solely at the discretion of Integrative Health Care. ***(If you are unable to make a scheduled appointment, please call the office as soon as possible at 831-459-6762 in order to avoid missed appointment charges. Voicemail is available for messages 24 hours/day every day).***
- ☐ I understand that three missed appointments without 24 hours prior notification may result in discharge from care, and further scheduling is solely at discretion of the practitioner.

Patient signature ______________________________ Date ____________________

Guardian signature ______________________________ Date ____________________