ROCHESTER REGIONAL HEALTH
Clifton Springs Hospital & Clinic
The Springs Integrative Medicine Center & Spa

NEW CLIENT REGISTRATION - PLEASE PRINT ALL REQUESTED INFORMATION CLEARLY

_____ _____ _____
PATIENT LEGAL NAME DATE OF BIRTH AGE

GENDER: □MALE □FEMALE HEIGHT _____ WEIGHT _____ MARITAL STATUS: □MARRIED □SINGLE □WIDOWED □DIVORCED

_____
ADDRESS CITY STATE ZIP

_____ _____
OCCUPATION EMPLOYER

( )_____ ( )_____ ( )_____EXT:_____
HOME PHONE CELL PHONE WORK PHONE

_____ _____
PARENT/GUARDIAN/LEGALLY RESPONSIBLE PARTY NAME (IF APPLICABLE) RELATIONSHIP

EMERGENCY CONTACT NAME_____ PHONE: ( )_____

HOW DID YOU HEAR ABOUT THE SPRINGS? _____

IF YOU WOULD LIKE TO RECEIVE EMAILS FROM THE SPRINGS, WE SEND – APPOINTMENT *REMINDERS, NEWS, EDUCATIONAL ARTICLES, SALES & PROMOTIONS VIA EMAIL.* *You may choose to unsubscribe at any time and your information will never be sold or shared with any other list.*
EMAIL:

Acknowledgement of Financial Policies
By signing below, I acknowledge that I understand the following policies:

- I will be required to **provide credit card information** to hold appointment times, **or prepay** for the scheduled service. You may pay for the service in any format you choose. We accept cash, checks, all major credit cards, and Spa Finder Gift Certificates.
- **Late Cancellation Policy:** Any late cancellation will incur a charge of 50% of the full session fee. We require 24 hours notice for single appointments & require a minimum of 48 hours notice to cancel or reschedule without incurring the 50% fee. Exceptions to the late cancellation policy may be granted at the discretion of the manager.
- **No Show Policy:** No shows will be charged 100% of the service fee for the scheduled appointments missed.
- There is a $15 fee for returned checks.
- Payment is due at the time of treatment.
- I will be responsible for full payment for my service, even if I am late for my appointment. It is my responsibility to arrive on time.
- I agree to keep my account balance current by paying at each visit.
- Unpaid fees over 90 days will be sent to collections or filed in court, unless prior arrangements have been made and past due accounts are kept current.

_____ _____ _____ _____
Printed name of patient Signature of Patient or Legal Guardian Date Time

INSURANCE INFORMATION REQUESTED ON REVERSE

ROCHESTER REGIONAL HEALTH
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PRIMARY INSURANCE INFORMATION – ACUPUNCTURE PATIENTS ONLY

_____ _____
NAME OF SUBSCRIBER SUBSCRIBER'S DATE OF BIRTH

_____ ( )_____
RELATIONSHIP TO PATIENT SUBSCRIBER PHONE NUMBER

_____ _____
NAME OF INSURANCE CARRIER/PLAN SUBSCRIBER ID# (INCLUDE ALL LETTERS & NUMBERS)

□ *I UNDERSTAND THAT INSURANCE COVERAGE FOR ACUPUNCTURE IS LIMITED & I HAVE CONTACTED MY INSURANCE COMPANY TO VERIFY COVERAGE AND POLICIES UNDER MY PLAN.*

FOR OFFICE USE ONLY:
INSURANCE VERIFICATION DATE _____ DEDUCTIBLE? □Y □N DEDUCTIBLE AMT REMAINING$_____ AS OF _____(DATE)

COVERAGE COPAY/COINSURANCE _____ APPROVED # VISITS: _____ OTHER _____

☐ RELEASE OF INFORMATION FOR PAYMENT & ASSIGNMENT OF BENEFITS

I AUTHORIZE AND DIRECT THE CLIFTON SPRINGS HOSPITAL AND CLINIC AND PHYSICIAN PROVIDERS HAVING TREATED ME, TO RELEASE TO GOVERNMENTAL AGENCIES, INSURANCE CARRIERS, AND OTHERS WHO ARE FINANCIALLY LIABLE FOR MY HOSPITALIZATION AND MEDICAL CARE, ALL INFORMATION NEEDED TO SUBSTANTIATE PAYMENT AND TO PERMIT REPRESENTATIVES THEREOF TO EXAMINE AND MAKE COPIES OF ALL RECORDS RELATING TO SUCH CARE AND TREATMENT. I HEREBY AUTHORIZE AND TRANSFER OVER TO THE CLIFTON SPRINGS HOSPITAL AND CLINIC AND PHYSICIAN PROVIDERS SUFFICIENT MONIES AND/OR BENEFITS TO WHICH I MAY BE ENTITLED FROM GOVERNMENTAL AGENCIES, INSURANCE CARRIERS, OR OTHERS WHO ARE FINANCIALLY LIABLE FOR MY HOSPITALIZATION AND MEDICAL CARE TO COVER THE COSTS OF THE CARE AND TREATMENT RENDERED TO MYSELF OR MY DEPENDENT IN SAID HOSPITAL.

☐ COORDINATION OF BENEFITS

I AGREE TO PROVIDE INFORMATION TO THE CLIFTON SPRINGS HOSPITAL AND CLINIC AND PHYSICIAN PROVIDERS FOR ALL GROUP HOSPITALIZATION, WORKER'S COMPENSATION OR OTHER HOSPITAL BENEFITS TO WHICH I MAY BE ENTITLED. I AUTHORIZE THE HOSPITAL TO BILL FOR SERVICES GIVEN TO ME ACCORDING TO THE CO-INSURANCE TERMS OF THESE CONTRACTS.
I UNDERSTAND THAT I MUST PROVIDE ALL NECESSARY BILLING INFORMATION TO THE CLIFTON SPRINGS HOSPITAL AND CLINIC WITHIN 30 DAYS OF THE DATE OF SERVICE. I UNDERSTAND THAT IF I DO NOT PROVIDE THE CLIFTON SPRINGS HOSPITAL AND CLINIC THE NECESSARY INFORMATION AND MY CLAIM IS NOT RECEIVED BY THE CARRIER ON OR BEFORE THE 45TH DAY, I WILL BE RESPONSIBLE FOR THE BILL.

PATIENT/GUARANTOR SIGNATURE_____DATE & TIME:_____
(IF MINOR, PARENT/GUARDIAN SIGNATURE – **MUST** INCLUDE RELATIONSHIP TO PATIENT)