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

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PRIMARY INSURANCE INFORMATION

COMPLETE THIS PAGE ONLY IF :
YOUR INSURANCE INCLUDES ACUPUNCTURE COVERAGE AND YOU ARE SEEKING TREATMENT FOR A COVERED DIAGNOSIS **OR** YOU ARE RECEIVING MASSAGE OR ACUPUNCTURE TREATMENT RELATED TO MOTOR VEHICLE ACCIDENT OR WORKER'S COMPENSATION INJURY.

_____ _____
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 TO VERY SPECIFIC DIAGNOSES. 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 _____

INJURY & ACCIDENT INFORMATION

ARE YOU SEEKING TREATMENT AS A RESULT OF AN ACCIDENT? ☐YES ☐NO ACCIDENT DATE _____/_____/_____

(PLEASE CHECK ONE) ☐MOTOR VEHICLE STATE MVA OCCURRED IN _____ ☐WORK ☐SCHOOL ☐LIABILITY

WHAT BODY PARTS WERE INJURED? _____

_____

ARE YOU RECEIVING OTHER TREATMENTS FOR THE ACCIDENT? ☐ YES ☐NO IF YES, WHAT TYPE OF TREATMENTS? _____

_____

IF YOU ARE RECEIVING PHYSICAL THERAPY, CHIROPRACTIC, & MASSAGE IN ANY COMBINATION, YOU CAN NOT RECEIVE TREATMENTS THE SAME DAY!

_____ ( )_____
NAME OF PHYSICIAN TREATING YOU FOR THE ACCIDENT PHYSICIAN PHONE #

THE FOLLOWING INFORMATION IS REQUIRED FOR ALL INJURIES & MUST BE FILLED OUT COMPLETELY:

_____ _____
NAME OF INSURANCE CARRIER CLAIM #

_____ ( )_____ x_____
ADJUSTER NAME ADJUSTER PHONE NUMBER EXTENSION

_____
ADDRESS OF INSURANCE CARRIER *CITY* *STATE* *ZIP*

FOR WORKER'S COMPENSATION CLAIMS, COMPLETE THE FOLLOWING:

_____
NAME & ADDRESS OF EMPLOYER NAME AT TIME OF INJURY

_____ ( )_____ x_____
HUMAN RESOURCES CONTACT NAME EMPLOYER PHONE NUMBER EXTENSION

_____ _____
CARRIER CASE # WORKER'S COMPENSATION #

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☐ 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.

☐ MEDICARE PATIENTS

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XVIII OF THE SOCIAL SERCURITY ACT IS CORRECT. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND THE CENTERS FOR MEDICARE AND MEDICAID SERVICES OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I ASSIGN THE BENEFITS PAYABLE FOR PHYSICIAN SERVICES TO THE PHYSICIAN OR ORGANIZATION FURNISHING THE SERVICES OR AUTHORIZE SUCH PHYSICIAN OR ORGANIZATION TO SUBMIT A CLAIM TO MEDICARE FOR PAYMENT TO ME.

☐ FINANCIAL AGREEMENT – GUARANTEE OF PAYMENT ☐ NO INSURANCE COVERAGE

FOR SERVICES RENDERED, I AGREE TO PAY ALL CHARGES RESULTING FROM THIS SERVICE AS STATEMENTS ARE PRESENTED, WITH FULL SETTLEMENT WITHIN 30 DAYS FROM THE DATE OF BILL.
IF I WILL BE UNABLE TO PAY THE HOSPITAL CHARGES IN FULL AS BILLED, I WILL CONSULT WITH THE HOSPITAL PATIENT REPRESENTATIVE (315) 462-0451 (L-Z) OR 0452 (A-K) TO MAKE SUITABLE PAYMENT ARRANGEMENTS AND DISCUSS FINANCIAL ASSISTANCE PROGRAMS AND QUALIFICATIONS.

☐ PERSONAL ARTICLES & EFFECTS

THE CLIFTON SPRINGS HOSPITAL AND CLINIC IS NOT RESPONSIBLE FOR LOST PERSONAL ARTICLES AND EFFECTS. I TAKE RESPONSIBILITY FOR RETAINING PERSONAL ARTICLES AND EFFECTS IN MY OWN POSSESSION.

☐ I HAVE RECEIVED A COPY OF AND UNDERSTAND THE PATIENT BILL OF RIGHTS.
☐ THIS FORM HAS BEEN EXPLAINED TO ME AND I HAVE RECEIVED OR BEEN OFFERED A COPY

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

GUARANTOR'S SIGNATURE_____ DATE & TIME:_____
(INCLUDE RELATIONSHIP TO PATIENT)

WITNESS SIGNATURE_____ DATE & TIME:_____

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ACKNOWLEDGEMENT OF
RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of Clifton Springs Hospital & Clinic's Notice of Privacy Practices.

_____ _____
Date Signature of Patient or Patient Representative

_____
Printed Name

_____
Witness

DOCUMENTATION OF
THE ATTEMPT TO OBTAIN WRITTEN
ACKNOWLEDGEMENT OF THE DELIVERY OF
THE NOTICE OF PRIVACY PRACTICES

I delivered the Clifton Springs Hospital & Clinic's Notice of Privacy Practices to

_____on_____. I attempted to obtain an acknowledgement of the receipt of Clifton Springs Hospital & Clinic's Notice of Privacy Practices but was unable to do so

because _____
_____
_____

_____ _____
Date Signature of Employee

_____
Printed Name