Patient Information Form

Last Name_____ First Name _____ Middle Name_____

Date of Birth (Required) _____ /_____/_____ Gender _____ Other names that records may be kept under _____

Address _____ City _____ State _____ Zip _____

SS# _____ Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

May we leave confidential voice messages for you at any of the above numbers? ☐No ☐Yes (specify) **☐Home ☐Work ☐Cell**
Are you currently employed? □ Yes □ No Employer_____

Emergency Contact Name_____ Phone # (_____) _____Relationship_____

How did you hear about us? _____

Guarantor Information

This section must be completed if someone other than the patient is financially responsible for the patient's account.

Last Name_____ First Name_____ Middle Initial _____

Address_____City_____ State_____ Zip_____

Phone (_____) _____Date of Birth (required) ____/____/____ SS#_____ Gender (circle) Male Female

Mother's Name (minors only)_____ Father's Name (minors only)_____

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient and that I am subject to all financial terms listed below.

X_____ _____
Guarantor's Signature (required) **Date**

Terms of Admission

Financial Terms: I understand that if I am insured with a Blue Star Naturopathic Clinic, P.C. (BSNC) contracted insurance company, BSNC will submit claims on my behalf. I also understand that I will be responsible for all charges whether or not they are covered by my insurance. Some procedures may be considered non-covered services and I will be required to make payment in full at the time of service. I understand that there is a cancellation policy and that I may be billed for missed appointments cancelled within less than 24 hours notice. I understand that finance charges will begin accruing on accounts that are 60 days past due at a rate of 1.5% per month. I further understand that overdue accounts will be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that any guarantor listed above is subject to the same financial terms as outlined in this paragraph and that my payment history, account balance and due dates may be disclosed to the guarantor for the purposes of securing payment. I understand that the guarantor, if someone other than myself; is not authorized to receive my medical information unless expressly authorized by me in writing.

Privacy Terms: We keep a record of the healthcare services we provide you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the record we keep. Moreover, if you believe that information in your record is inaccurate, you may also request that we correct or amend that record. We will not disclose your medical information to others unless you direct us to do so or applicable laws authorize or compel us to do so. Blue Star Naturopathic Clinic, P.C. is required to provide you with a copy of its Notice of Privacy Practices and to obtain written acknowledgement that you have received it. The notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning the management of your healthcare information at our clinic, wish to inquire about your rights or if you wish to schedule an appointment to view your medical record, please call (541) 389-6935.

I hereby acknowledge that I have received a copy of Blue Star Naturopathic Clinic P.C. Notice of Privacy Practices. Should I fail to sign this form, I acknowledge that Blue Star Naturopathic Clinic, P.C. has made good faith effort to obtain my acknowledgment.

X_____ _____
Patient's Signature **Date**

X_____ _____
Guardian/Representative's Signature **Date**

X_____
Relationship to Patient/Representative authority