Helios Integrated Medicine

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Patient Registration

Date: _____/_____/_____

Patient Name: _____

Address: _____ City: _____

State: _____ Zip: _____

Primary Phone: (_____) _____-_____ Alternative Phone: (_____) _____-_____

Email Address: _____

Is it ok to leave a voice mail at these numbers? Yes ____ No _____

Date of birth _____/_____/_____ Age _____ Gender: Male / Female

Social Security Number (optional): _____-_____-_____

Credit card Number (optional) _____

Expiration date: ____/____ CVV Code _____

Who to notify in an emergency:

Name: _____Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone number: (_____) _____-_____ Alternative Phone: (_____) _____-_____

- I understand that payment is due at the time of service.
- I understand that I am ultimately responsible for payment of services and/or supplies.
- I understand that I am responsible for understanding my individual insurance coverage.
- I will make any dispute of charges at the time of service. All charges will remain as charged on the day of service.
- I understand that I WILL be charged a fee for appointments that are not cancelled within 24 hours.
- I understand that I WILL be charged a maximum fee of $25.00 for each returned check.

Signature: _____ Date: _____/_____/_____