Confidential Patient Information

First Name:_____ M:_____ Last Name:_____

Address:_____

City:_____ State:_____ Zip:_____

DOB:_____ Phone #:_____

May we leave a confidential voicemail message at the above phone number? Circle Yes No

Email:_____

May we add your email address to our email distribution list for our periodic newsletter and other periodic informational emails and offers? Circle: Yes No

Emergency Contact: _____ Phone #:_____

Health Insurance:_____ID #_____

How did you hear about us?:_____

Reason for visit:_____

_____

_____

Please list your top three health goals/priorities:

_____

_____

_____

Are you experiencing any of the following?:

☐ Fatigue	☐ Depression	☐ Weight Gain
☐ Anxiety	☐ Sleep Disturbance	☐ Stress
☐ Gas/Bloating	☐ Skin rash/itching	☐ Chronic Pain

Do any of the following conditions run in your family?

☐ Cancer	☐ Diabetes	☐ Heart Disease

Financial Terms: I understand that if I am insured with a TRND contracted insurance company, TRND is required to 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 or appointments cancelled with 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 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.

I hereby acknowledge that I have received a copy of Teresa Richter, ND's Notice of Privacy Practices. **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 above.** Should I fail to sign this form, I acknowledge that TRND has made a good faith effort to obtain my acknowledgement.

X _____ _____

Patient's Signature Date