North Country Holistic Care Center
PATIENT REGISTRATION FORM

Patient Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone #: Home: _____ Cell: _____

Email _____

Date of Birth: _____ Age: _____ Sex: M F

Social Security #: _____-_____-_____ Referred by: _____

_____

Employment Information

Employer: _____ Phone #: _____

Address: _____ Occupation: _____

_____

Billing Information

Name of Insurance Company: _____

I.D.#: _____ Group #: _____

2nd Secondary Insurance Company: _____

I.D.#: _____ Group#: _____

Person That The Insurance Is Carried By:

Name: _____ D.O.B: _____ Sex: M F

S.S#: _____-_____-_____ Relationship to Patient: _____

_____

Emergency Contact Information

Name: _____

Phone #: _____ Relation: _____

PRIMARY CARE PHYSICIAN

Name: _____

I hereby authorize direct payment of medical benefits to North Country Holistic Care Center for services rendered. I understand that I am financially responsible for any balance not covered by my insurance company. I hereby authorize the release of any medical or incidental information for medical care or the processing of medical claims.

Patient/Guardian Signature: _____ Date: _____

North Country Holistic Care Center
Health History Form

Patient Name:_____ Date of Birth:_____

Hospitalizations

YEAR	ILLNESS/OPERATION	YEAR	ILLNESS/OPERATION

Past Medical/Family History

	SELF	RELATION		SELF	RELATION
recent weight loss			kidney/bladder problems		
migraine headaches			neurological		
epilepsy/convulsions			arthritis		
eye disease			osteoporosis		
hearing disorder			cancer: *TYPE*		
recurrent nose bleeds					
sinus/throat infections			bleeding disorders		
angina-chest pain			blood transfusions		
heart attack			anemia		
high blood pressure			diabetes		
stroke			thyroid		
high cholesterol			alcohol/drug abuse		
heart valve disorder			mental illness		
lung disease			depression		
stomach ulcer			psoriasis/eczema		
bowel problems			hair loss		
liver disease/hepatitis			major accidents		
other:			other:		

MEDICATIONS YOU TAKE	DO YOU USE?	DRUG ALLERGIES	DATES YOU HAD:
	CIGARETTES Y N		FLU VACCINE:
	ALCOHOL Y N		HEPATITIS VAC:
	COFFEE/TEA Y N		T.B. TEST:
	STREET DRUGS: Y N		STOOL TEST:
	TYPE:		CHOL. TEST:
			TETANUS SHOT:
			PAP TEST:
			MAMMOGRAM:

North Country Holistic Care Center
461 Glen Street
Glens Falls, NY 12801

Financial Policy

By executing this agreement you agree that all services you receive will be paid for in full by yourself and/or your insurance company.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, finance charges and payment/credits received during the month.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Insurance: Insurance coverage is a contract between you and your insurance company. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by your insurance.

Co-Payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance company requirement, we cannot bill you for these.

Finance Charge: A finance charge will be imposed on your account if it has not been paid within 30 days of the service date. The finance charge rate is 1% per month or an annual percentage rate of 12%. The minimum finance charge is $.50.

Returned Checks: There is a $50 fee for any checks returned unpaid by the bank.

Missed Appointment Fees: **Medical patients** who do not show up for a scheduled appointment or cancel with less than 24 hour notice will be charged a $30 fee for office visits and $50 for physicals. **Acupuncture/Holistic consult patients** who do not show for a scheduled appointment or cancel with less than 24 hour notice will be charged full price of the service.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we refer your account to a collection agency, you agree to pay all of the collection costs incurred, including attorney fees and court costs. In case of suit, you agree the venue shall be in Warren County, New York.

Photocopying of Records: You will need to request in writing, and pay a copying fee of $.75 per page to receive copies of your medical records or transfer them to another doctor.

Workers Compensation: We require written approval/authorization by your employer and/or workers compensation carrier as well as a claim # and claim submission address prior to your initial visit for a work-related injury. If your claim is denied, you will be responsible for payment in full.

I have read and agree to the terms of this financial policy.

Patient Name: _____ Patient Date of Birth: _____

Patient Signature: _____ Date: _____

Relationship: _____

Revised 10/30/2014

NORTH COUNTRY HOLISTIC CARE CENTER

Diane MacDonnell, MD *Paul Alagna, MD*

ACUPUNCTURE/HOLISTIC PAYMENT WAIVER

Insurance regulations require that we inform you in advance if we believe a service may not be covered or fully reimbursed by your insurance company.

The service of acupuncture with/without electrical stimulation for treatment of your medical condition may not be paid for by your insurance company.

The service of a holistic consult may not be paid for by your insurance company.

PATIENT AGREEMENT

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE INFORMATION. I HAVE ADVISED THE DOCTOR TO PROCEED WITH THE SERVICES TODAY WHETHER OR NOT THEY ARE COVERED BY MY INSURANCE COMPANY. IF MY INSURANCE COMPANY DENIES PAYMENT, I AGREE TO BE PERSONALLY AND FULLY RESPONSIBLE FOR PAYMENT IN FULL FOR THE SERVICES RENDERED.

_____ _____

PATIENT/GUARDIAN SIGNATURE Date

_____ _____

Witness Date

North Country Holistic Care Center
461 Glen Street
Glens Falls, NY 12801

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I give my consent for North Country Holistic Care Center to use and disclose protected health information about me to carry out treatment, payment, and healthcare operations. (North Country Holistic Care Center's Notice of Privacy Practices provides a more complete description of such uses and disclosures). I have the right to review the Notice of Privacy Practices prior to signing this consent.

I give permission for North Country Holistic Care Center to CALL my home or other alternative location and leave a message on voice mail or in person information regarding the following:

Appointment Reminders
Insurance Items
Collection of Debts
Laboratory/Diagnostic Testing Results
Medication Information

I give permission for North Country Holistic Care Center to MAIL to my home or other alternative location the following information:

Patient Statements
Appointment Reminder Cards
Laboratory/Diagnostic Testing Results
Insurance Items

By signing this form, I am consenting the North Country Holistic Care Center's use and disclosure of my information as described above.

I may revoke my consent in writing except to the extent that the practice has already made disclosures based on my prior consent. If I do not sign this content, or later revoke it, North Country Holistic Care Center may decline to provide treatment to me.

Patient name	Signature of Patient or Guardian
Print Name of Patient	Date

NORTH COUNTRY HOLISTIC CARE CENTER

Diane MacDonnell, MD *Paul Alagna, MD*

AUTHORIZATION FOR PRACTICE TO RELEASE INFORMATION TO THIRD PARTIES

Patient Name: _____

Date of Birth: _____

By signing this authorization, I authorize North Country Holistic Care Center to use and/or disclose protected health information (PHI) about me to the party or parties listed below.

Name(s) of third parties: _____
_____
_____

Individually identifiable health information to be released: _____
_____

This authorization will expire on: January 1, 2029.

When my information is used or disclosed pursuant to this authorization. It may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPPA privacy rule. I have the right to revoke this authorization in writing except to the extent that North Country Holistic Care has acted in reliance upon this authorization. My written revocation must be submitted to North Country Holistic Care Center's privacy office at 461 Glen Street, Glens Falls, NY 12801.

Signature of Patient or Guardian: _____

Relationship to Patient: _____

Print patient/Guardian Name: _____

Date: _____