LIVacupuncture

NEW PATIENT REGISTRATION

We are committed to providing the best, most comprehensive care possible. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in the following to the best of your ability.

***Please also sign our Financial and Privacy Policy. ***

Today's Date			Patient ID#		
PATIENT INFORMATION					
Patient Last Name	First	Middle	Patient DOB	Age	Gender
Parent 's Name if Patient is a Minor					
Home Address			City	State	ZIP Code
Mailing Address (If different)					
Home Phone	Cell Phone	Texts OK?	E-mail		
Employer			Occupation		
Marital Status	Spouse/Partner Name (Last, First)				
Primary Care Physician (PCP) Name			PCP Phone		
Chiropractor, Physical Therapist, or Other Therapist					
EMERGENCY CONTACT					
Name			Relationship to Patient		
Address	City	State	Zip		
Best Number to reach them at in case of Emergency only ( )					
Nearest Relative (not living with you)			Phone		

INSURANCE INFORMATION			
Were You Injured on the Job? **YES NO**		Have you Informed Your Employer? **YES NO**	
NO FAULT, P.I.P, or Worker's Compensation? **YES/NO**			
Do you have ***ACUPUNCTURE*** Insurance Coverage?			
Insurance Company:		Insurance ID #	
Subscriber Last Name First Middle		Subscriber DOB:	Relation to Patient
Group #	Subscriber Employer	Is this patient Covered by another insurance? *(If yes, please provide Insurance name and ID #)*	

BILLING INFORMATION			
Bill To Last Name First Middle		Relation to Patient	
Billing Address	City	State	ZIP Code
Credit Card to have on file for (1) year for Acupuncture Billing use unless (you) notify (us) of alternative payment method:			
Circle: VISA M/C	Credit Card Number:		
Name as it appears on Credit Card	EXP Date (MM/YY)	CSV Code *(From Back of Card)*	

Please provide a copy of your current insurance card and driver's license.

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to LIV Acupuncture. I authorize the clinician to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of acupuncture care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care with LIV Acupuncture, any fees for professional services will be immediately due and payable. I understand that interest and any fees related to collections may be charged for overdue accounts.

The patient understands and agrees to allow this acupuncture office to use their patient health information for the purposes of treatment, payment, healthcare operations and coordination of care as outlined in the LIV Acupuncture Financial and Privacy Policy.

Signature of Patient: _____ Date_____

(Parent/Guardian if under 18)

LIVacupuncture

Patient First and Last Name (Please Print)

Financial and Privacy Policy

At LIV acupuncture we believe in offering our patients choices when it comes to their own health care. This holds true with our financial and privacy policy. Your health is our first priority so we offer a variety of financial options, allowing us to focus on your health.

Currently LIV acupuncture is an in-network provider for both Excellus and MVP insurance plans if your specific policy provides coverage for acupuncture treatments. Patients with insurance must provide a copy of their current insurance card and driver's license for verification of benefits. Once coverage is determined, all co-pays, deductibles and other payments are due in full at the time services are rendered. Patients without insurance will also be served according to our current fee schedule, which is available upon request. We accept **checks, cash, and credit cards.**

Cancellation Policy
The practitioner may charge a $45 no-show fee for appointments not cancelled 24 hours in advance

Privacy Policy
We are required to collect and maintain personal information about you and are required by law to disclose the following:

Types of Personal Information We Collect
Personal and health information about you that is provided by you when you fill out the patient registration form.

Parties to Whom We Disclose Information
For current and former patients, I do not disclose any personal or health information obtained in the course of my practice except as required or permitted by law for billing your insurance company for payment of services. Permitted disclosures include providing information to your insurance company who needs to know that information to assist in providing reimbursement for services that you have received.

Protecting the Confidentiality and Security of Current and Former Patient's Information
Records are maintained relating to professional services, as required by professional law, and to be able to assist with professional needs and services. In order to guard your nonpublic personal and health information, physical, electronic, and procedural safeguards that comply with professional privacy standards are in place.

Employee Authorization and Accountability
Any person employed within this facility shall sign a contract waiver of accountability regarding exposure to all private information. No employee shall change, alter or deform any information without prior approval from a supervisor or within the contract guidelines of their operating position. Any employee found to have violated the privacy policy shall be deemed on probation pending investigation and possible termination upon immediate notice.

I acknowledge that I have read and understand the Financial and Privacy Policy as stated above:

Signature: _____ Date: _____
(Parent/Guardian if under 18)