DEMOGRAPHICS AND RELEASE

DEMOGRAPHICS

NAME: AGE: DATE OF BIRTH:

BEST CONTACT PHONE:

EMAIL FOR FORMS AND PORTAL:

ADDRESS: STREET

CITY: STATE: ZIP:

DOCTORS:

Doctor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYMENT HISTORY: What has your occupation been over the past year? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary insurance company name:

Primary insurance member ID number:

Primary insurance address:

Primary insurance phone number:

Primary card holder’s name:

Primary card holder’s date of birth:

Primary card holder’s street address:

City: State: Zip:

Secondary insurance company name:

Secondary insurance member ID number:

Secondary insurance address:

Secondary insurance phone number:

Secondary card holder’s name:

Secondary card holder’s date of birth:

Secondary card holder’s street address (if different than yours):

City: State: Zip:

**ASSIGNMENT AND RELEASE**

I, the undersigned verify that, to the best of my knowledge, the information above is correct. I assign directly to ACI Medicine all insurance benefits. If any, otherwise payable services are rendered, I understand that I am financially responsible for changes whether or not paid by insurance. **By signing this form you fully understand that ACI Medicine is not a participant of Medicaid or Medicare and will not provide services to** **Medicaid or Medicare patients at this time.** I hereby authorize release of information necessary to secure the payment of benefits. I authorize the use of this signature in all insurance submissions.

*Signature Relationship Date*

#### ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have been offered or have received a copy of the Privacy Notice.

Patient Name: Date: Signature of Patient: Date: Signature of Representative: Date:

Relationship to Patient:

**MESSAGE AUTHORIZATION**

Patient Name: Date of Birth: / /

**Please Circle Yes or No for the following questions:**

Do you give the staff at ACIM permission to leave messages on your voice mail?

Do you give the staff at Rejuvanation permission to leave messages on your voice mail?

**YES NO**

Do you give the staff at ACIM permission to discuss your health care issues with your spouse or other designated person?

Do you give the staff at Rejuvanation permission to discuss your health care issues with your spouse or other designated person?

**YES NO**

If yes, please list spouse/designated individuals and phone contacts:

Signature: Date:

Witnessed by: Date:

Date:

The following allows ACI Medicine to obtain records from your previous or current health care provider (if you have one).

I, , hereby authorize and request:

Name Date of Birth

Heathcare Provider: Address:

City:

State: Zip:

to provide records to the office personnel at the Iowa and Illinois offices of:

**Advanced Center for Integrative Medicine**

880 Tanglefoot Lane

Bettendorf, Iowa 52722

The entire medical record

**REASON FOR RELEASE: Request from health care clinician who is treating.**

**The information to be released is confidential. Further disclosure by the receiving party is strictly prohibited except as specifically authorized.**

I understand that I may revoke this consent at any time, except if action has already been taken in regards to this request. This consent automatically expires upon compliance of this request and will not serve for any future request.

**SIGNATURES:**

**­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient or legal guardian signature Relation to patient Date