Northern California Center for Lifestyle Medicine

P: 916-500-1315
www.ncclm.com

Patient Information

Last Name: _____ First Name: _____ Middle Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Ph:(_____)_____ Work Ph:(_____)_____ Cell Ph:(_____)_____

May we leave confidential voice-mail messages for you at any of the above numbers? ❍ No ❍ Yes (specify): **❍ Home ❍ Work ❍ Cell**

Email: _____

Date of Birth: _____ Age: _____ Gender:_____ Other names that records may be kept under: _____

Employer/Occupation: _____

Mother's Name (minors only): _____ Father's Name (minors only): _____

Emergency Contact (name and number):_____

Relationship to Emergency Contact: _____

How did you hear about our center? _____

The following information is optional

Marital Status *(circle one):* Single/Never Married Married Divorced Separated/Not Divorced Widowed Domestic Partnership

Number of members in your household: _____ **Do you have children? If yes, please list ages: _____**

Terms of Admission

<u>Financial Terms:</u> I understand that The Center for Natural Health & Living does not contract with insurance companies. For this reason, payment for office visits is requested at time of service, rates are listed below.

New Patient Visit: $250
Follow up Visits (in-office, phone and Skype) prorated at: $250/hour

Privacy Terms: We keep a record of the healthcare services we provide you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the record we keep. Moreover, if you believe that information in your record is inaccurate, you may also request that we correct or amend that record. We will not disclose your medical information to others unless you direct us to do so or applicable laws authorize or compel us to do so.

X _____ _____
Patient's Signature Date

X _____ _____
Guardian/Representative's Signature Date

_____
Relationship to Patient/Representative Authority

<u>Cancellation Policy:</u> Significant time and effort is required preparing for each visit. As such, appointments cancelled with less than 48 hours notice will result in a fee equal to 25% of the full office visit fee. Appointments cancelled with less than 24 hours notice will be charged 50% of the full office fee. No shows, with no advanced cancellation will be charged full visit fee.

X _____ **(Please initial after reading and agreeing to cancellation policy above)**

(Reviewed on 1-1-13)