

REGISTRATION FORM

Sterling Hart, ND

1054 Melrose St. Winston Salem, NC 27103

(Please Print)

Today's date:			PCP:				
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
May we contact you via email? <input type="checkbox"/> Yes <input type="checkbox"/> No	Email Address:		Cell Phone:		Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: ()		
P.O. box:	City:		State:		ZIP Code:		
Occupation:	Employer:			Employer phone no.: ()			
Chose clinic because/Referred to clinic by (please check one box):			<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan		<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages		<input type="checkbox"/> Other		
Other family members seen here:							

IN CASE OF EMERGENCY				
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.:	Work phone no.:
			()	()
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.				
_____ <i>Patient Signature (Legal Guardian if patient is a minor)</i>			_____ <i>Date</i>	

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent for treatment and stating that you understand and agree with how your records will be used.

1. The client understands and agrees to allow Core Wellness Center to use their Client Health Information (CHI) for the purpose of treatment, payment, health care operations, and coordination of care.
2. The client has the right to examine and obtain a copy of his/her own health records at any time and request corrections
3. A client's written consent need only be obtained one time for all subsequent care given the client in this office.
4. The client may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Clients have the right to file a formal complaint with our clinic about any possible violations of these policies and procedures.
6. If the client refuses to sign this consent for the purpose of treatment, payment and health care operations, the naturopathic physician has the right to refuse to give care.

Consent To treatment

I _____ hereby consent, authorize and request Sterling Hart, ND to administer the treatment deemed advisable and necessary to my (my ward's) condition in accordance with her expertise. I agree to hold her free and harmless from any claims, suits for damages or complications which may result from such treatment.

I have read and understand all the above and I agree to these policies and procedures.

Client's Signature: _____

Date: _____

Guardian's Signature: _____

Date: _____