



www.EvolutionaryMed.com • (541)241-3135 • info@EvolutionaryMed.com

Personal & Work Information

Date: _____
Patient Name: _____ Date of Birth: _____
Preferred Name: _____ Gender: _____ SSN: _____ Mobile Phone: _____
Address: _____ Home Phone: _____
City: _____ State: _____ Zip: _____ Email: _____
Employer: _____ Occupation: _____ Work Phone: _____
Emergency Contact: _____ Relationship: _____ Phone(s): _____
PCP Name / Clinic: _____ PCP Phone: _____
How did you find us? _____ [] Opt out of reminder texts [] Opt out of quarterly e-newsletter

Financial & Insurance Information

[] I will pay my balance in full at time of service (Do not fill out below)

Insurance Company: _____ ID# _____ Group# _____
Secondary Insurance: _____ ID# _____ Group# _____

Complete the following information about the Insurer if other than self: Relationship: [] Spouse [] Child [] Partner
Name: _____ Date of Birth: _____

Motor Vehicle Accident or Workers Compensation (if Applicable):

Insurance Company: _____ Date of Accident / Injury: _____
Claim Number: _____ Adjuster's Name: _____ Phone: _____

Records Release & Assignment of Insurance Benefits

The undersigned hereby authorizes the Release of Information relating to claims for benefits submitted. I agree and acknowledge that I authorize my physician / practitioner to submit claims for benefits, for services rendered, without obtaining my signature on each claim.

I (patient) _____ hereby authorize (Insurance Co.) _____ to pay and hereby assign directly to EvolutionaryMedicine LLC all owed benefits. I understand I am financially responsible for all incurred charges.

X
Patient Signature (or Guardian if patient is under 18 years of age) Relationship to patient Date

Notice of Privacy Practices (HIPAA)

I have had the opportunity to review the privacy practices of Evolutionary Medicine LLC, regarding my protected health information.

X
Patient Signature (or Guardian if patient is under 18 years of age) Relationship to patient Date

Consent & Agreement

Any procedure intended to help may have complications. These complications may include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, minor burns, and temporary worsening of symptoms. More serious complications are extremely rare. Please call your practitioner if you have any concerns. Additional information on side effects and complications can be found in the Acupuncture Informed Consent to Treat form.

Please be respectful of your practitioner and give 24 hours of notice for cancellation. Failing to do so will result in a \$25 cancellation fee. Failing to show up for an appointment without a phone call will result in a fee of half the price of the treatment scheduled. Reminder emails are sent out 36 hours prior to appointment time.

I have read and understand the above statements and I understand that there is no guarantee for a specific outcome of treatment.

X
Patient Signature (or Guardian if patient is under 18 years of age) Relationship to patient Date