Evolutionary Medicine LLC

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? _____ ☐Consent to receive reminder texts ☐Consent to receive 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 then 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 therapist's time 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 may result in a fee of half the price of the treatment scheduled. Courtesy reminder texts are sent out the day of the appointment.

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