



**Inland
Naturopathic**
WELLNESS CENTER

Regenerate Optimize Heal

New Client Information

Legal Name: _____ / _____ / _____ Age: _____
Last First Sex Date of Birth
Perm. Address: _____ City: _____ State: _____ Zip: _____
Temp. Address: _____ City: _____ State: _____ Zip: _____
Phone Perm: (____) _____ Cell Phone: (____) _____ Phone Work: (____) _____
Texting Notifications? Y N Email Address: _____ May we send you our email newsletter? Y N

Referral Information

How did you hear of us? _____ Referral by: _____
 Website Google Yelp Facebook CNDA AOAPRM ACAM

Were you referred by another physician or health provider: YES NO

Please provide us with as much information as possible for the Referring Physician?

Referring Physician/health provider's Name: _____
Address, City, State, Zip: _____
Telephone Number: _____

Additional Patient Information

Today's Date: ____ / ____ / ____ MD/DO Physician: _____
Employer: _____ Occupation: _____
Work Address: _____ City: _____ State: _____ Zip: _____
Name of nearest relative not living with you: _____ Relation: _____ Phone: (____) _____
Marital Status (circle): Single Married Separated Divorced With Partner Widow(er)
Name of Spouse (or parent for minor child): _____ Number of Children: _____
Whom may we contact in case of an emergency: _____ Relationship to you: _____
Emergency Contact #: (____) _____

Insurance Information

Insurance Company: _____ Phone: (____) _____
Name of Insured: _____ Relationship to the Insured: _____
Policy #: _____ Group #: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and me. I clearly understand and agree that all services rendered to me are charged directly to me and are due at the time of service.

Furthermore, in the event that payment is not made on this account and it is placed with a licensed collection agency, I/we agree to pay the fees of the collection agency equal to the maximum of 50% of our outstanding balance at the time of the account is placed with the agency. Should legal action also be necessary to collect the account, I/we agree to pay attorney's fees and court costs incurred for the collection.

Office Policy requires payment at time of services.

Signatures

Client's Signature

(Minor) Parent/Guardian's Signature

____ / ____ / ____
Date

New Client Office Policy

Your medical services will be provided by one of our doctors. All INMC doctors are licensed in the state of California. By signing you give consent to medical evaluation and treatment by one of our doctors. Your doctor may recommend various methods to help maintain or re-establish your health and he will discuss those methods with you. Chronic medical conditions often require lifestyle changes which may take time for effect. We ask your commitment to these changes, along with follow-up visits as naturopathic medicine seeks cure of illness rather than suppression of symptoms. In the event that chelation therapy or prescription medications such as thyroid hormone are used in your therapy, periodic laboratory retesting is required for ongoing therapy. All prescription refills require 48-hour notice for processing.

We are not contracted with insurance carriers. Therefore, payment is due at the time of service. If you would like insurance reimbursement, we will provide you with a super-bill to submit to your insurance provider. PPO carriers such as Aetna, Cigna, Great Western, Pacific Care and United Health Care often provide patients with at least partial reimbursement, however, we cannot guarantee reimbursement.

_____ **INITIAL.** A **\$25 fee** is required for letters written by the physician. Additional review of medical records, lab results, or questions received via email or phone that are outside of an appointment will be charged an appointment fee.

CANCELLATION/RESCHEDULE POLICY:

We have a **24-hour cancellation/reschedule policy**. Please call the office within 24 hours prior to your scheduled appointment if you need to reschedule or cancel. A **\$35.00 fee** will be charged for appointments not changed in this manner.

_____ **INITIAL.** A service fee of **\$25.00** will be applied to any returned checks.

I guarantee payment of all charges incurred as a patient of the Inland Naturopathic Medical Center, Inc. I understand that no warranty or guarantee of cure as a result of care is provided for any treatment.

YOUR PRIVACY:

All information provided by you to our doctors and the Inland Naturopathic Medical Center, Inc. is confidential. A signed medical release form is required before your medical records or information can be released to any person other than the patient.

I understand that INMC doctors do not to maintain hospital admitting privileges. In the event of an emergency, I understand that I will need to contact my primary care provider and go to the nearest urgent care center or emergency department.

REFUND POLICY FOR ANCILLARY SERVICES:

Please be advised of our refund policy regarding the purchase of packaged services:

_____ **INITIAL.** Refunds for un-used treatments are less 15% up to 14 days after purchase. Refunds are not given after 14 days from purchase. Refunds are paid within 30 days of request. Upon refund, all used treatments will be charged at our full price rate rather than the discounted rate. There are no refunds on treatments used.

SUPPLEMENT REFUND POLICY:

_____ **INITIAL.** Unopened supplements may be returned for full refund up to 14 days from date of purchase. We do not grant refunds for opened supplements or those purchased outside of 14 days. We do not provide refunds for custom made formulas such as botanical tinctures and powdered formulas.

By signing below, I agree that I have read and understood this policy.

Signature: _____

Date: _____

Print Name: _____

Parent or Guardian (minor): _____

Date: _____