Inland Naturopathic
WELLNESS CENTER
Regenerate Optimize Heal

New Client Information

Full Legal Name: _____ _____ _____
Last First Middle

Age: _____ **Date of Birth:** _____/_____/_____ **Sex**: ☐ Male ☐ Female

Permanent Address: _____

City: _____ **State**: _____ **Zip**: _____

Mailing Address: _____
(if different than above)

City: _____ **State**: _____ **Zip**: _____

Preferred Phone: ☐ Mobile ☐ Home ☐ Work **Texting Notifications OK?** ☐ Yes ☐ No

Cell Phone: _____ **Home Phone**: _____ **Work Phone**: _____

E-mail: _____ **May we send you our email newsletter?** ☐ Yes ☐ No

Additional Client Information

MD/DO Physician: _____

Employer: _____ Occupation: _____

Work Address: _____ City: _____ Zip: _____

Name of nearest relative not living with you: _____ Relation: _____ Phone: _____

Marital Status (circle): ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Partnered ☐ 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 Phone Number #:** _____

Referral Information

How did you hear of us? _____ ☐ Referral by: _____

☐ Website ☐ Google ☐ Yelp ☐ Facebook ☐ CNDA ☐ AOAPRM ☐ ACAM ☐ A4M

Were you referred by another physician or health provider: ☐ NO ☐ YES: _____
Name of Referring Physician

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

Referring Physician's Address: _____

City, State, Zip: _____ Phone Number: _____

Insurance Information

Insurance Type: ☐ PPO ☐ HMO Insurance Company: _____

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.

New Client Office Policy

Your medical services will be provided by one of our doctors. All INWC doctors are licensed in the state of California. By signing you give consent to medical evaluation and treatment. Your doctor may recommend various methods to help maintain or re-establish your health and (s)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. If chelation therapy or prescription medications such as thyroid hormone are used in your therapy, periodic laboratory retesting is required for ongoing therapy. All 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.** I guarantee payment of all charges incurred as a patient of the Inland Naturopathic Wellness Center, Inc. I understand that no warranty or guarantee of cure as a result of care is provided for any treatment.

_____ **INITIAL.** A service fee of **$35** will be applied to any returned checks.

_____ **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 **48-hour cancellation/reschedule policy**. Call the office within 48 hours prior to your scheduled appointment if you need to reschedule or cancel. A **$50 fee** will be charged for late cancellations and no-shows.

YOUR PRIVACY:

All information provided by you to our doctors and the Inland Naturopathic Wellness 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 INWC doctors do not maintain hospital admitting privileges. In the event of an emergency, I understand that I will need to contact my primary care provider and/or go to the nearest urgent care center or emergency department.

REFUND POLICY FOR THERAPIES & TREATMENTS:

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 beyond 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: _____
(for minors only)

Media Consent & Release

Inland Naturopathic Wellness Center requests permission to photograph me, take motion pictures of me, take video footage of me, and/or make electronic sound recordings of me (herein referred to as photographic or electronic reproductions) as a patient of Inland Naturopathic Wellness Center. Photos may be used for medical education, patient education, and business marketing.

Inland Naturopathic Wellness Center also requests permission of the use of your name(s) for the purposes stated above. I understand that my name and photograph will not be used for any other purposes. I agree to make nofinancial claims in regards to the use of said photographs and will not hold Inland Naturopathic Wellness Center liable for any damages gleaned from the use my name and said photograph/s.

By signing below, I, _____, hereby authorize Inland Naturopathic
Print Name
Wellness Center to use of any such photographic or electronic reproductions of me for any purpose, including, but not limited to educational and other public media as may be deemed appropriate by Inland Naturopathic Wellness Center. I understand that I may be identifiable from such photographic or electronic reproduction.

I have read and understood this consent and release.

_____ _____
Signature of Patient *Date*

☐ By checking this box, I hereby **decline** authorization for the use of photographs, motion pictures, video footage and/or electronic sound recordings of me (herein referred to as photographic or electronic reproductions). I do not permit the use of these materials for medical education, patient education and business marketing.

PARENTAL CONSENT FOR MINORS (under the age of 18 years)

I certify that I, _____, am the parent/ guardian of _____, a minor under the age of eighteen years. I hereby agree to assume legal responsibility for his/her authorizations referred to in this consent and release.

_____ _____
Signature of Patient's Parent/Guardian *Date*