



New Patient Registration Form

Date: _____

Patient's Name: _____ DOB: _____ Male Female

Home Address: _____ City: _____ State: _____ Zip: _____

(For parents, use sections below)

Home Telephone #: _____ Mobile #: _____ Work #: _____

E-mail: _____

Employer: _____ Occupation: _____

Insurance Company: _____

Claim Mailing Address: _____

Insured Name: _____ Relation to Patient: _____

Insurance ID #: _____ Group #: _____

Who may we thank for your referral? _____



Patient's Name: _____

Authorization for Integrative Medical Treatment

I authorize the practitioners at Vibrant Life Medicine to administer such medical and health care services, treatments and procedures for me as they deem appropriate and necessary.

I understand that my practitioner will prescribe an integrative treatment program for me which may include conventional medical care, nutritional therapies, acupuncture, homeopathy, herbal medicine, traditional Chinese medicine, functional medicine, massage therapy, and other aspects of integrative medical treatment. As a patient seeking integrative medical treatment, I understand that I must decide, in conjunction with my practitioner, what course of treatment will best benefit me. I understand that any or all of the above referenced treatment modalities may be considered unproven or experimental by other doctors, medical agencies, or third party payers and may not be reimbursable.

I understand that the benefits and/or risks and dangers of any treatment program prescribed by my practitioner will be explained to me to my full satisfaction. I understand that if any explanations as to the benefits and/or the risks and dangers of any of the prescribed treatment programs are unclear, it is my responsibility to ask for clarification before giving my consent to treatment. While I understand that there have been no warranties or assurances of successful outcome for myself, I nevertheless desire to pursue integrative medical treatment for myself after having considered all factors, including the information contained herein.

I understand that it is my responsibility to contact Vibrant Life Medicine to report any issues that I am having with the treatment program, and to schedule consult time to make program adjustments and to conduct appropriate testing. I am responsible for seeking professional medical attention from my practitioner at Vibrant Life Medicine or another facility if I experience any unanticipated or unpleasant effects associated with treatment or a worsening my condition. If an emergency medical condition arises, I will seek treatment for myself immediately from the nearest emergency department or by calling 9-1-1.

_____ Initial

Please initial here and sign the last page to indicate you have read and accept the terms of this section.



Patient's Name: _____

Authorization for Payment

I hereby authorize Vibrant Life Medicine to charge my account balance to the credit card indicated below. I authorize this credit card to be used as a guarantee against late cancellations and missed appointments, and for any and all balances including those relating to office visits, telephone/e-mail consultations, missed/late appointments, miscellaneous fees, and charges for nutritional supplements. I agree that if my credit card does not accept the charge, I will immediately make payment to Vibrant Life Medicine for the amount due. I understand that I may cancel this authorization in writing at any time.

Visa/MC (circle type) #: _____ Exp Date: _____ Security Code: _____

Authorized signature: _____

Cancellation Policy

I understand that I am expected to keep all my appointments as scheduled in order to ensure maximum progress in my treatment. I understand that the practitioner's time is reserved exclusively for my care for the duration of all scheduled visits, and that if I am late for my visit, the visit will end at the scheduled time and I will still be charged for the full visit time. If for some reason I cannot make an appointment, I will call at least **3 business days in advance** to cancel or reschedule that visit. I understand that if I cancel an appointment **less than 3 business days** prior to the scheduled time, I will be charged a fee that represents 50% of the cost of my scheduled appointment. I further understand that if I cancel **less than 1 business day** before my appointment, or fail to show for my appointment, I will be charged a fee that represents the full cost of my scheduled appointment.

_____ Initial

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Telephone/E-mail Policy

I understand that non-urgent calls that occur after hours or on weekends, or telephone calls over 10 minutes that occur at any time will be billed at the same consultation rate as in-person visits and charged to my credit card on file.

I further understand that e-mails which take over 10 minutes to read and reply will be billed at the in-person consultation rate and charged to my credit card on file. By sending an e-mail, I acknowledge and agree that a prompt reply is NOT required, expected, or contemplated. I acknowledge that I will not use e-mail communication to deal with emergencies or other time-sensitive issues. I understand that e-mail communications may not be secure and that there is some possibility that confidentiality of such communications may be breached by a third party. I understand that Vibrant Life Medicine may keep copies of e-mail communications and that such messages may be included in your, or your child's, medical record.

_____ Initial

Please initial here and sign the last page to indicate you have read and accept the terms of this section.



Patient's Name: _____

Receipt of Vibrant Life Medicine Policies and Notice of Privacy Practices

I hereby acknowledge that I have read and agree to the terms stated in the Vibrant Life Medicine document titled **Vibrant Life Medicine Policies**.

I claim full financial responsibility for all services rendered at Vibrant Life Medicine. I understand that payment is required in full at the time of service. I understand that fees may change without notice.

I understand Vibrant Life Medicine is not contracted with any insurance plans, and that my, or my insurance plan may not reimburse for services rendered at Vibrant Life Medicine, including office visits and telephone/e-mail consultations. I also understand that some of the lab tests that are ordered, particularly those that are used in support of integrative consultations, or that are kits sent to labs using innovative approaches to diagnostics, may also not be reimbursed.

I understand that it is my responsibility to know my insurance plan benefits. I understand that Vibrant Life Medicine will assist in filing an insurance claim on my behalf as a courtesy, but that all pre-authorizations for visits and follow-up for insurance claims is my responsibility.

I hereby acknowledge that I have read and agree to the terms stated in the Vibrant Life Medicine document titled **Notice of Privacy Practices** and consent to the use and collection of personal and medical information described herein.

_____ Initial
Please initial here and sign the last page to indicate you have read and accept the terms of this section.

Authorization to Release Information to Insurance Carrier

I authorize Vibrant Life Medicine to submit to my insurance carrier any information acquired in the course of my examination or treatment which may be required to process my claim for payment.

_____ Initial
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Acknowledgement that Dr. Erica Song is not my Primary Care Doctor

I understand that while Dr. Song will not function as my primary care physician, she will gladly coordinate care with any of my other healthcare providers.

_____ Initial
Please initial here and sign the last page to indicate you have read and accept the terms of this section.

Responsible Party's Signature

Date: _____

Relation to Patient: _____