ELIXIA
wellness group

NEW PATIENT PERSONAL INFORMATION, PAYMENT POLICIES, CONSENT

Full Legal Name: _____ Today's Date: _____

Preferred Name: _____ **Date of Birth**: _____ Occupation: _____

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

Phone (c): _____ (work): _____ (home/other): _____

Email: _____

Emergency Contact: _____ **Ph #**:_____ Relation: _____

Sex ☐ Male ☐ Female Pronoun preference ☐ He/Him ☐ She/Her ☐ They/Them

Gender Identity (if different than Sex)

☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Genderqueer ☐ Non-binary

Employment Status (select all that apply)

☐ Employed ☐ Full-time student ☐ Part-time student ☐ Military
☐ Retired ☐ Veteran ☐ Unemployed

Marital Status

☐ Single ☐ Married ☐ Domestic Partnership ☐ Divorced ☐ Widowed

How did you hear about our clinic?

☐ Internet search ☐ Referral/Practitioner ☐ Friend ☐ Family Member ☐ Patient
☐ Facebook ☐ Instagram ☐ Drive/walk by ☐ Advertisement ☐ Other _____

Insurance Details

Insurance Company: _____ ID #: _____

Plan name, if available: _____ Group: _____

Relationship to Insured: ☐ Self ☐ Spouse* ☐ Child* ☐ Other*

**If not Self, please list primary insured's name*: _____

Please sign all the following sections indicating you have read and agree to all statements

Email Policy

By signing below, I understand that my email will be used solely to grant Patient Portal* access (a link will be sent to access a secure, HIPAA-compliant site), for Appointment Reminders (sent 1 week and 1 day prior to appointments), and E-Newsletters (occasional notification of news, events and partitioners specific to Elixia and FoRM Health practitioners). I understand I can opt out of email appointment reminders by verbal or emailed notification to the front desk at info@elixiawellness.com. I understand that I can opt out of newsletters at any time by selecting unsubscribe in the newsletter email. Emails are NEVER sold or distributed. *You are advised to use the Patient Portal to directly communicate with your practitioner but not all practitioners choose to use the portal as a way to communicate with their patients; discuss individually with your practitioner.

Patient Signature: _____ Date: _____

Name: _____

Scheduling and Cancellation Policies

We require a valid credit card to be authorized and held on file at least 24 hours before the initial visit is scheduled*. This credit card is stored in an encrypted database through our credit card processor and will be charged only if fees are incurred in accordance with the following guidelines for appointment scheduling, cancellations and no-shows.

*Appointments made within 24 hours of the start of a visit may require a deposit for the FULL OUT-OF-POCKET COST of the new patient visit. Following visit completion, deposit will be returned less any incurred visit charges or applicable insurance copays, co-insurance, or deductible. Deposit is non-refundable if the patient no-shows or arrives more than 15 minutes after the appointment time.

We require at least 24 hours notice via phone call or voice message for Tuesday through Saturday appointments, or by 2pm on Saturday for Monday appointments, to change, modify, or cancel any visits or procedures NOT requiring a deposit. Cancellations or modifications not meeting these guidelines will be subject to missed appointment fees as follows.

FEES

For NEW Visits, defined as the first appointment within the last 3 years with a specific provider, a $100 missed appointment fee will be charged.

For ESTABLISHED/RETURN Visits NOT involving procedures listed below, a $60 missed appointment fee will be charged. Some providers may allow a 1 time exemption for first time incidents.

For PROCEDURES involving IV therapy, Neurofeedback, and all non-PRP Injections, including those purchased as part of a package, a $100 missed appointment fee will be charged.

DEPOSITS

For PROCEDURES involving PRP (platelet rich plasma) or cosmetic/aesthetic laser, a Non-Refundable deposit in the amount of $300 for PRP and $200 for Laser may be required when scheduling. If scheduling online, a deposit will be collected with a call before the appointment is confirmed. Appointments are allowed to be rescheduled up to 2 times, according to the above notification requirements, or deposit will be forfeited.

I understand the cancellation policies and associated fees, and have provided a valid credit card number (either in person, verbally over the phone, or signed and submitted on printed credit card authorization form) to be charged in accordance with the above stated policies.

Patient Signature: _____ Date: _____

Financial Responsibility and Assignment of Benefits

OUT OF POCKET PAYMENTS. If your visit will not be covered by an insurance plan, or if you fail to provide proof of insurance, payment in full is expected at each visit. A time of service discounted rate, varying by provider, may be offered. This does not apply to supplements, lab diagnostics, and may not apply to aesthetic, IV or injection therapies.

PATIENT BILLING. Based on the insurance information we verify, all calculated co-pays, coinsurance or deductible charges are due at the time of your visit. In the case of any additional charges based on the explanation of benefits from your insurance carrier, all balances are due within 30 days of billing. Any bills outstanding over 30 days may accrue finance charges and a billing fee of $1.50 for each billing cycle that the statement goes unpaid. Any accounts not paid within 90 days are subject to 12% finance charge and may be referred to an outside collection agency. By signing this agreement you also authorize the office to release information needed to secure payment.

RETURNED CHECKS. If your check is returned, there will be a $25.00 Returned Check fee owed, in addition to the amount of the check. 12% collection charge per month will be added for non-payment.

Name: _____

INSURANCE COVERAGE. We verify insurance, however, we do not guarantee coverage based on our findings. It is your responsibility to know the benefits and limitations of your own insurance plan. Elixia cannot guarantee that all services billed will be covered as quoted; all plans have specific exclusions based on medical necessity which we cannot always determine until the claim is processed by your insurance carrier.

To authorize an insurance carrier to provide timely and accurate payment to Elixia for any services furnished THE PATIENT AGREES:

- I certify that the insurance information that I have provided is accurate, complete and current, and that no other coverage or insurance exists.
- I assign the right to receive payment of authorized benefits to Elixia.
- I request that payment of authorized benefits be made on my behalf to Elixia for any services furnished for patient listed by Elixia's physicians and health care providers.
- I authorize Elixia to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided.
- If my Health Insurance Plan will not direct payment to Elixia, I agree to forward to Elixia all health insurance payments which I receive for the services rendered by Elixia and its health care providers.
- I authorize Elixia, holder of medical information about me or the patient listed, to release to my Health Insurance Plan any information needed to determine these benefits, or the benefits payable for related services.

I further acknowledge and agree:

- That I am responsible for all charges for services provided to the patient listed which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan.
- That I agree to pay all charges which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan after review of the claim.
- I further agree that, if permissible by law, I will reimburse Elixia for all costs, expenses and attorney's fees that may be incurred by Elixia to collect those charges.
- That this financial form with assignment of benefits applies and extends to subsequent visits and appointments at Elixia.

I have read and understand all of the listed policies and agree to abide by these guidelines. If using insurance, I assume responsibility for any charges not paid or deemed "non-covered' by my insurance carrier.

Patient Signature: _____ Date: _____

Notice of Privacy Practices and Informed Consent

By signing below, I am indicating that I have read and agree to the Elixia Wellness Group Privacy Practices (separate document). I have also read the Informed Consent (separate document) and am aware of the risks and benefits of services and therapies provided by Elixia Wellness Group. I agree to these services, EXCEPT any selected here:

☐ DO NOT agree to Chiropractic manipulation ☐ DO NOT agree to Acupuncture & Chinese Medicine

☐ DO NOT agree to Naturopathic medicine ☐ DO NOT agree to Massage, bodywork, or manual therapy

Patient Signature: _____ Date: _____