PROLOTHERAPY NOW™
REGENERATIVE THERAPIES

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: _____

☐ ProlotherapyNow ☐ GetProlo ☐ AOAPRM ☐ ACAM ☐ CNDA ☐ Google ☐ Yelp ☐ Facebook

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 the 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 INWC 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. Insurance companies do not pay for or provide reimbursement for Prolotherapy/Regenerative Injection Therapy. If you would like insurance reimbursement for your visit we will provide a super-bill to submit to your insurance provider. PPO carriers such as Aetna, Cigna, Great Western, Pacific Care and United Health Care may provide patients with partial reimbursement for visits, 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 Wellness 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 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 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: _____