WELCOME TO

THE CENTER FOR ALTERNATIVE MEDICINE

New Patient Information Packet:

All pages are scanned into our computer.

Please complete fully, legibly, and accurately .

① ADMISSION AGREEMENT

② PATIENT REGISTRATION INFORMATION

③ PRIVACY PRACTICES CONSENT FORM

④ HEALTH & NEEDS INFORMATION

⑤ INSURANCE BILLING INFORMATION

For appointments with Dr. John MacCallum, your initial appointment will be scheduled upon our RECEIPT of this COMPLETED PACKET. You may mail it or drop it off in person.

For appointments with other providers at our office, appointments may have already been scheduled. Please bring this COMPLETED PACKET with you (or arrive 20 min. early to complete one in the office, so as not to use up part of your scheduled time).

Please tear off & KEEP this cover page and the Insurance Billing Information⑤

Thank you for choosing us to help with your health and well-being!

DIRECTIONS: The Center for Alternative Medicine is located at 100 Prestige Park, Suite 300-B, Hurricane, WV. From I64, take the Teays Valley/Winfield exit and turn onto Rt. 34 toward Winfield.. We are only a minute from the Interstate. Turn right into Prestige Park just before Rt. 34 begins to curve to the left. From Winfield, Prestige Park is on the left just after the last curve on Rt. 34 before the long straight section to the Interstate. Our office is in the last building you will come to, the second suite from the left. Ample front parking is available.

304-757-3368

Patient Registration: THIS PAGE IS SCANNED INTO OUR COMPUTER !

EVERY LINE MUST BE ACCURATELY & LEGIBLY COMPLETED OR MARKED N/A (not applicable)
for accurate billing on your behalf. Thank you.

Full Name ______________________ Social Security #______________

Address ______________________ City ____________ State ______ Zip ______
Sex ______ Birth Date ___/___/___ E-Mail ______________________
Marital Status ☐ Married ☐ Single Home Phone (___) ______________
☐ Divorced ☐ Widowed Cell/Mobile (___) ______________
☐Employed ☐Retired ☐Full Time Student Work Phone (___) ______________
☐ Disabled ☐Other ______________ Employer ______________________
Referring Physician? ______________ How did you hear of us? ______________

DO WE BILL YOUR INSURANCE ? (see our Insurance Billing Information sheet in your packet)

☐Medicare ☐Medicaid Insurance Company ______________________
Submit claims address ______________________
Insured/Card Holder's Name ______________ Relationship ______________
Insured's Address ______________________ Insured's Birth Date ______________
Policy/ID # ______________ Group # ______________ Phone ______________

SECONDARY INSURANCE ? (only if we bill your primary insurance)

☐ Medicare ☐Medicaid Insurance Company ______________________
Submit claims address ______________________
Insured/Card Holder's Name ______________ Relationship ______________
Insured's Address ______________________ Insured's Birth Date ______________
Policy/ID# ______________ Group # ______________ Phone ______________

EMERGENCY CONTACT

Name ______________________ Relationship ______________
Home Phone (___) __________ Work Phone (___) __________ Address ______________
____

RESPONSIBLE PARTY (other than self) — SPOUSE / PARENT / GUARANTOR (CIRCLE ONE)

Full Name ______________________ Relationship ______________
Social Security # ______________ Birth Date ___/___/___ Sex ______________
Daytime Phone (___) ______________ Employer ______________________
Address ______________________ City ____________ State ______ Zip ______

AUTHORIZATION FOR PAYMENT COLLECTION AND RELEASE OF INFORMATION

I hereby authorize payment of any applicable Medical Benefits directly to the Physician /Provider /Center, realizing that I am responsible for full payment of all non-covered service fees. I also hereby authorize the Provider to release any information acquired in the course of my treatment necessary to process insurance claims or collection procedures.

SIGNATURE ______________________ *DATE* ______________
(If patient is a minor, parent or guardian signature is required)

CENTER FOR ALTERNATIVE MEDICINE

PATIENT CONSENT
TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS.

I understand I have the right to review the Center for Alternative Medicine Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices is provided for me at the Center. _______________ client initials

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information (PHI) that will occur in my treatment, payment and billing, or in the performance of healthcare operations of the Center for Alternative Medicine. My "protected health information" means health information, including my demographic information (name, address, phone numbers and other) that is collected from me and created or received by my healthcare providers or health insurers. This PHI is related to my past, present and/or future physical or mental health conditions, and identifies me, or there is reasonable basis to believe the information may identify me. The Notice also describes other potential releases of my PHI that may occur with or without my specific authorization.

The Center for Alternative Medicine reserves the right to change the privacy practices that are described in the Notice. The Center for Alternative Medicine will provide to me, by mail or in person, a copy of any revisions to the Notice upon my request.

I understand that I have the right to request restrictions on how my PHI is used or disclosed to carry out treatment, payment or healthcare operations. The Center for Alternative Medicine is not required to agree to the requested restrictions, however, if there is agreement, the restrictions are binding upon the Center for Alternative Medicine until the agreement is terminated.

By signing this form, I consent to the Center for Alternative Medicine to use and disclose my PHI for treatment, payment and billing, and other healthcare operations and acknowledge provision of the Notice of Privacy Practices.

I additionally choose to give permission to the Center for Alternative Medicine to share information regarding my conditions, treatment, payments, billing, and/or healthcare operations with the following persons:

_______________________________ _______________________________

_______________________________ _______________________________

_______________________________ _______________

Signature of Client (12 years or older) Date

_______________________________ _______________

Signature of Parent/Legal Representative Date

_______________________________ _______________

Witness Signature Date