REGISTRATION FORM

Name _____ Date _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell _____

Email _____ Is this a work account? Yes No May we contact you by email? Yes No

Where may we leave messages? ___Home phone ___Work phone ___Cell ___Email ___ Other _____

Personal Information

Social Security Number _____

Gender _____ Marital Status _____ Number of children _____ Ages/Gender _____

Occupation _____ Employer/School _____

Parent/Guardian (if minor) _____ Occupation _____ Phone _____

Emergency Contact _____ Relationship _____ Phone _____

Insurance

Insurance Co _____ Group # _____ ID # _____

Primary Insured Name _____ Birthdate _____ Phone _____

Responsible Party Information (To be completed if someone other than you is financially responsible for your account.)

Name _____ Address _____ Phone _____

Assignment of Benefits (To be completed by the person financially responsible for your account.)

I authorize payment directly to HeartSong Health In Community, Inc. and Dr. Ani Hawkinson for health insurance benefits payable to me under the terms of my policy and I agree to assist in the processing of claims for benefits. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature _____ Relationship _____ Date _____

Acknowledgement of Financial Policy

• Payment: Payment for noncovered services, laboratory tests, and pharmacy items are due at the time of service. Only cash and personal checks are accepted. Sliding fees, payment plans, and bartering are available if arranged prior to receipt of services or purchase of products.

• Insurance: If you wish us to bill insurance, please provide your insurance information prior to your first visit. Co-pays are due at the time of service.

• Pharmacy returns: A full credit or refund will be issued if the supplement is returned unopened within 15 days, less shipping charges. After 15 days, no credit or refund will be issued. No returns are allowed on tinctures or on special orders.

• Phone consultations: Calls to clarify instructions on an existing treatment plan are free of charge if less than five minutes. If longer, they will be billed as an office visit, at increments of ten minutes. Prescribing over the phone is considered an office visit.

• Email: Emails to clarify instructions of an existing treatment plan are free of charge if they do not require more than five minutes to answer. If they require more time, time will be billed as an office visit, at increments of ten minutes. No new diagnosing or prescribing can be done via email.

• Missed Appointments: You will be billed the full cost for missed appointments if notice is not given at least 24 hours in advance.
You will be billed $30 for missed appointments if notice is given within 24 hours in advance.

• Overdue Balances: If you receive a statement for an overdue balance, payment is expected within 2 weeks of the billing date.
If you cannot make payment within 2 weeks of the billing date, please call 802-387-2345 to make alternative payment arrangements.

Signature of Person Financially Responsible for Your Account _____ *Date* _____

HeartSong Health In Community
36 Old Town Road Putney, VT 05346
T: 802-387-2345 F: 802-387-5311