



Patient Registration Form

Patient Information

Name _____ Social Security # _____

Date of birth _____ Age _____ Sex: Male Female

Address _____

City _____ State _____ Zip _____

Phone _____ (h) _____ (w) _____ (c)

Fax _____ Email _____

Primary Care Physician _____

Marital Status (check one): single married divorced widowed

Insurance Information

Insurance Provider _____ Plan Name _____

Insurance ID# _____

If the insurance is in the name of someone other than yourself, please complete the following:

Name of insured _____ Date of birth _____

Relationship to Patient _____

Address if different than above _____

Employer Information

Employer Name _____

Address _____

City _____ State _____ Zip _____ Phone _____

Emergency contact information

Name _____ Relationship to you _____

Phone _____ (h) _____ (w) _____ (c)

How did you hear about our office? _____

Referred by: _____
(name) (address)

I authorize Avena Wellness Center LLC to release medical records pertaining to my treatment to any entity that is responsible for payment of the charges. I also authorize payment of benefits directly to Avena Wellness Center LLC.

Signature of Patient _____ Date _____

Signature of Guardian _____ Relationship to patient _____
(if different from patient)



Financial Policy

Thank you for trusting Avena Wellness Center LLC, where we are committed to providing the best holistic health care possible. Please understand that the payment of your bill is considered part of your treatment. The following statement explains our financial policy. Please read the policy, sign and return it to us prior to your treatment.

I, _____, understand I am responsible for payment of any charges and agree to pay Avena Wellness Center LLC the regular charges for all medical services rendered to me. It is my responsibility to check with my insurance provider to determine if this is a covered benefit. If I am covered by one of the following insurance providers: Anthem/BCBS, ConnectiCare, Healthnet, Meritain Health or MultiPlan, then they may pay all or a part of the charges. If so, I agree to pay those charges that are not covered by or paid by that insurance provider as soon as I receive the bill. If I do not pay my bill, I agree to pay Avena Wellness Center LLC any collection costs it may incur. Avena Wellness Center LLC reserves the right to accept periodic installment payments without waiving its right to demand payment in full.

If your insurance provider is not listed above, your payment is due at the time services are provided. We accept cash, check, debit cards, Visa, MasterCard, American Express and Discover. A superbill will be provided for you to send to your insurance provider for reimbursement if you have out-of-network benefits.

Returned Checks

For checks returned to us as unpaid by your bank, you will be charged a \$25.00 fee. Any legal fees that we incur to secure past due balances will be added to your account.

Missed Appointments

Please provide at least 24 hours notice of cancellation as a courtesy. Our policy is to charge \$25.00 for missed appointments without appropriate notice. Please help us to serve you better by keeping scheduled appointments.

I understand that I am financially responsible for the charges that I incur during my treatment under the care of Avena Wellness Center LLC. This includes all Naturopathic therapies, supplements, office visits, laboratory and imaging charges. I have read and agree to the financial policy.

Signature of Patient _____ Date _____

Name of Guardian _____ Relationship _____

Signature of Guardian _____ Date _____



Informed Consent For Treatment

I, _____, hereby authorize the physicians of Avena Wellness Center LLC to perform the following procedures as necessary to facilitate my diagnosis and treatment:

Common Diagnostic Procedures: e.g. venipuncture, laboratory, x-ray, imaging tests.

Physical Examination: may include but not limited to any of the following: Skin & Dermatology; Head, Ear, Eyes, Nose & Sinuses & Throat; Face & Neck; Lungs & Pulmonary; Chest & Cardiovascular; Abdominal; Hands, Arms & Lower Limbs; Reflexes; Motor Skills; Back and Spine; Cranial Nerves; Male Genitalia, Prostate & Rectal Exams; Female Genitalia, Breast Exams; Mini-Mental Status Exams; Nutritional Exams.

Medicinal use of Nutrition: e.g. therapeutic nutrition, nutritional supplements.

Botanical Medicine: botanical substances may be prescribed as teas, alcoholic tinctures, nonalcoholic tinctures, capsules, powders, tablets, creams, ointments, plasters or suppositories.

Homeopathic Medicine: the use of highly dilute quantities of naturally occurring plants, animals and minerals to stimulate the body's natural healing responses.

Chinese Medicine: e.g. acupuncture, cupping, electrical stimulation, TDP lamp, Chinese herbal medicine.

Lifestyle Counseling and Biofeedback: e.g. diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.

Naturopathic Physical Medicine: e.g. muscle stretching/massage, hot and cold therapies, constitutional hydrotherapy.

I recognize the potential risks and benefits of these procedures as described below:

Potential Risk: allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from procedures.

Potential Benefits: restoration of health and body's maximum functional capacity without the use of drugs or surgery, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease of its progression.

Notice to Pregnant Women: all female patients must inform the doctor if they know, suspect, or may be pregnant as some of the therapies used could present a risk to the pregnancy and fetus.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Avena Wellness Center LLC regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I understand that a record will be kept of health services provided to me. This record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted by law.

Signature of Patient _____ Date _____

Name of Guardian _____ Relationship _____

Signature of Guardian _____ Date _____



Acknowledgment of Acceptance of Notice of Privacy Practices

Printed Name

Date of Birth

I hereby acknowledge that Avena Wellness Center LLC has provided me with a copy of its Notice of Privacy Practices. I also understand that I am entitled to receive updates upon request if Avena Wellness Center LLC amends or changes its Notice of Privacy Practices in a material way. I understand that if I have questions or complaints I may contact:

avena wellness center LLC
243A Kennedy Dr.
Putnam, CT 06260

Signature

Relationship to Patient

Date

THIS SECTION IS TO BE COMPLETED BY THE AVENA WELLNESS CENTER IF UNABLE TO
OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT

I attempted to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above named patient, but was unable to for the following reason:

Patient declined to sign the written acknowledgment

Other (specify): _____

Name and Title of Employee

Date