The WellBridge
CLINIC

Personal & Work Information

Date ______________________ Patient Name ____ Age ______

Birth Date _____/_______/_______ Gender _________________ Pronoun____________ Mobile Phone ___________________________

Address ____ Work Phone _____________________

City ____ State__________________________ Zip ___________

Occupation ______________________ Employer ___________________________________Work Phone _________________________

Email____

Emergency Contact:________________________Relationship ______________________ Phone(s) ________________________________

How did you learn about our practice? ____

☐ I would like to receive text message reminders of my appointments

Primary Care Physician ________________________________Clinic _______________________ Phone _________________________________

Name of Specialist 1 _________________________________ Clinic _______________________ Phone _________________________________

Name of Specialist 2 _________________________________ Clinic _______________________ Phone _________________________________

May we contact your health care team and update them of your care and progress? ☐ Yes ☐ No

Financial & Insurance Information

Please choose one ☐I will pay my balance in full at time of service. ☐Please bill my insurance; I will present you with my insurance card

Insurance company ______________________________________ ID#_____________________________ Group#_________________________

Secondary Insurance_____________________________________ ID#_____________________________ Group#_________________________

Complete the following information about the *Insured* if other than self: Name_____________________________________ ☐M ☐F

Birth Date ____/____/____Full Address ____

Relationship to Insured ☐Self ☐Spouse ☐Child ☐Partner ☐Parent

Motor Vehicle Accident or Workers Compensation:

Insurance Company:__________________________________ Claim Number:________________________ Date injured:________________

Adjuster's Name:____ Adjuster's Phone:____

I understand the following (please initial):

____ 1. The WellBridge Clinic offers payment plans to ensure that money does not become an obstacle to health.
____ 2. Personal and health information are private and protected by HIPAA.
____ 3. There is a $50 fee for any appointment missed or not canceled 24 hours in advance.
____ 4. Insurance does not cover fee for missed appointment or appointments canceled in less than 24 hours.
____ 5. Health insurance and personal injury insurance is not a guarantee of payment for services rendered at The WellBridge Clinic.
____ 6. Insurance benefits quoted by insurance companies are not a guarantee of payment.
____ 7. Balances unpaid by insurance companies will be paid by the patient.
____ 8. The WellBridge Clinic is unable to refund or exchange herbs, nutritional supplements or other products.

I (patient)________________________________ hereby authorize (Insurance Co.) ____
to pay and hereby assign directly to The WellBridge Clinic all owed benefits. I understand I am financially responsible for all charges incurred.

____ ______________________________ ________________
Patient Signature or Guardian if patient is under 18 years of age   Relationship to patient   Date