Integrative Health Specialists of Indiana

(317) 580-9333-phone/ (317) 818-8933-fax

Patient Registration Form

Account Number:

Patient Name (first, middle, last) Patient Address City					
City	Patient Name (first, middle, la	ast)			
Telephone(s) Home () Work () Cell () Date of Birth SSN# Marital Status Email Medication Allergy Referred by	Patient Address				
Date of BirthSSN#Medication Allergy Referred by	City		State	Zip	
Email	Telephone(s) Home ()	Work ()	Cell ()	
Pharmacy Name:	Date of Birth	SSN#	Mar	rital Status	
Employer Address	Email	Medication Allergy_	Re	eferred by	
Emergency Contact List one person we have permission to contact Name Relationship Phone() Address City/State/Zip Policyholder Information Self Pay Date of Birth Address City/State/Zip Name Date of Birth Address City/State/Zip SSN# Home Telephone () Relationship to Patient Work Telephone () Family Doctor Phone Number () Work Telephone () I request payment of benefits to be made to Integrative Health Specialists (IHS) for any services furnished to me by this group. I authorize any holder of medical information about me to release to the insurance carrier(s) and its agents any information needed to determine these ber or the benefits payable for related services. I recognize that if my insurance carrier(s) requires a referral and/or authorization for any or all services rendered, the undersigned shall be personally obligated to pay for any services for out of network charges. In consideration services rendered, the undersigned shall be personally obligated to pay for any services one covered by health insurance or any other source of reimbursement. I agree to pay IHS for any amounts not paid by my insurance carrier for medical services rendered. I am also responsible for any attornized to pay for any services rendered by health insurance or any other source of reimbursement. I agree to pay IHS for any amounts not paid by my insurance carrier for medical services rendered. I am also responsible for any attornized to collect for these services, court costs and collection agency fees. NOS-DNO-POLICY There will be a \$50.00 fee for not canceling appointments at least 24 hours prior to scheduled time. Initial Here for Authorization to Pay and No-Show Policy Today's Date	Pharmacy Name:		Phone #:		
Emergency Contact List one person we have permission to contact Name Relationship Phone() Address City/State/Zip Policyholder Information Self Pay Name Date of Birth Address City/State/Zip SSN# Home Telephone () Relationship to Patient Work Telephone () Family Doctor Phone Number() Family Doctor Phone Number() No Are Not Primary Care Initial Here AUTHORIZATION TO PAY BENEFITS TO PROVIDER AND TO RELEASE INFORMATION I request payment of benefits to be made to Integrative Health Specialists (IHS) for any services furnished to me by this group. I authorize any holder of medical information about me to release to the insurance carrier(s) and its agents any information needed to determine these ber or the benefits payable for related services. I recognize that if my insurance carrier(s) requires a referral and/or authorization, I will held financially liable for the full amount of the charges for services rendered. I am also responsible for out of network charges. In consideration services rendered, the undersigned shall be personally obligated to pay for any services not covered by health insurance carrier referred and/or authorization, I will held financially liable for the full amount of the charges for services rendered. I am also responsible for out of network charges. In consideration services rendered, the undersigned shall be personally obligated to pay for any services not covered by health insurance or any other source of relimbursement. I agree to pay iHS for any amounts not paid by my insurance carrier for medical services rendered. I am also responsible for any authorization agency fees. NOS-ION POLICY There will be a \$50.00 fee for not canceling appointments at least 24 hours prior to scheduled time. Initial Here for Authorization to Pay and No-Show Policy Today's Date	Employer		Status: 🖵 Full-1	time □Part-time □Retired □	None
Relationship	Employer Address		City/State	/Zip	
Policyholder Information Self Pay Date of Birth				_Phone()	
Name	Address		City/State/Zip _		
Name	Delia de de la fermatica	Colf Dov			
Address			Data of	Dinah	
Relationship to Patient Work Telephone () Work Telephone () Phone Number() Work Telephone () Phone Number() Work Telephone ()					
Relationship to Patient					
Family Doctor Phone Number()					
AUTHORIZATION TO PAY BENEFITS TO PROVIDER AND TO RELEASE INFORMATION I request payment of benefits to be made to Integrative Health Specialists (IHS) for any services furnished to me by this group. I authorize any holder of medical information about me to release to the insurance carrier(s) and its agents any information needed to determine these ber or the benefits payable for related services. I recognize that if my insurance carrier(s) requires a referral and/or authorization for any or all service rendered by IHS that I am responsible for obtaining the referral and /or authorization. In the absence of such referral and/or authorization, I will held financially liable for the full amount of the charges for services rendered. I am also responsible for out of network charges. In consideration services rendered, the undersigned shall be personally obligated to pay for any services not covered by health insurance or any other source of reimbursement. I agree to pay IHS for any amounts not paid by my insurance carrier for medical services rendered. I am also responsible for any attorney fees required to collect for these services, court costs and collection agency fees. NO-SHOW POLICY There will be a \$50.00 fee for not canceling appointments at least 24 hours prior to scheduled time. Initial Here for Authorization to Pay and No-Show Policy Today's Date	Relationship to Patient		Work Telephone ()	
AUTHORIZATION TO PAY BENEFITS TO PROVIDER AND TO RELEASE INFORMATION I request payment of benefits to be made to Integrative Health Specialists (IHS) for any services furnished to me by this group. I authorize any holder of medical information about me to release to the insurance carrier(s) and its agents any information needed to determine these ber or the benefits payable for related services. I recognize that if my insurance carrier(s) requires a referral and/or authorization for any or all service rendered by IHS that I am responsible for obtaining the referral and /or authorization. In the absence of such referral and/or authorization, I will held financially liable for the full amount of the charges for services rendered. I am also responsible for out of network charges. In consideration services rendered, the undersigned shall be personally obligated to pay for any services not covered by health insurance or any other source of reimbursement. I agree to pay IHS for any amounts not paid by my insurance carrier for medical services rendered. I am also responsible for any attorney fees required to collect for these services, court costs and collection agency fees. NO-SHOW POLICY There will be a \$50.00 fee for not canceling appointments at least 24 hours prior to scheduled time. Initial Here for Authorization to Pay and No-Show Policy Today's Date	Family Doctor		Phone Number(()	
I request payment of benefits to be made to Integrative Health Specialists (IHS) for any services furnished to me by this group. I authorize any holder of medical information about me to release to the insurance carrier(s) and its agents any information needed to determine these ber or the benefits payable for related services. I recognize that if my insurance carrier(s) requires a referral and/or authorization for any or all service rendered by IHS that I am responsible for obtaining the referral and /or authorization. In the absence of such referral and/or authorization, I will held financially liable for the full amount of the charges for services rendered. I am also responsible for out of network charges. In consideration services rendered, the undersigned shall be personally obligated to pay for any services not covered by health insurance or any other source of reimbursement. I agree to pay IHS for any amounts not paid by my insurance carrier for medical services rendered. I am also responsible for any attorney fees required to collect for these services, court costs and collection agency fees. NO-SHOW POLICY There will be a \$50.00 fee for not canceling appointments at least 24 hours prior to scheduled time. Initial Here for Authorization to Pay and No-Show Policy Today's Date	We Are Not Primary Care	Initial Here			
	I request payment of benefits to be any holder of medical information or the benefits payable for related rendered by IHS that I am responsi held financially liable for the full an services rendered, the undersigned reimbursement. I agree to pay IHS attorney fees required to collect for	e made to Integrative Health Specialists about me to release to the insurance ca services. I recognize that if my insurance ble for obtaining the referral and /or authorized for the charges for services render a shall be personally obligated to pay for for any amounts not paid by my insuranthese services, court costs and collect NO-SHC	(IHS) for any services furnish arrier(s) and its agents any in the carrier(s) requires a referrithorization. In the absence red. I am also responsible for any services not covered by nice carrier for medical servicion agency fees. DW POLICY Dintments at least 24 hours por prization to Pay and No-Show	hed to me by this group. I authorize information needed to determine these be ral and/or authorization for any or all serv of such referral and/or authorization, I will or out of network charges. In consideration, y health insurance or any other source of ces rendered. I am also responsible for an prior to scheduled time.	vices ill be n of
rationt/nesponsible raity	Patient/Responsible Party		Today's Date _	revised 5/2024	_