

BEDFORD NATURAL MEDICINE
Patient Information Form

Last name _____ First name _____ Middle name _____
Date of birth _____ Gender _____ Nickname, preferred name _____
Address _____ City _____ State _____ Zip _____
SS# _____ Home Phone _____ Work phone _____ Cell _____

May we leave confidential voice mail message for you at any of the above numbers?
Home _____ **Work** _____ **Cell** _____

Employer/School _____
Mothers name (minors only) _____ Fathers name (minors only) _____

Emergency contact name _____ Contacts phone number _____
Relationship to emergency contact _____ Do you have special needs?

How did you hear about my office?

Guarantor Information

This section must be completed if someone other than the patient is financially responsible for the patients account

Last name _____ First name _____ Middle name _____
Address _____ City _____ State _____ Zip _____
Phone _____ Date of birth _____ SS# _____ Gender _____

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above named patient and that I am subject to all financial terms listed below.

X _____

Guarantors signature required
date

Terms of Admission

Financial terms: I understand that there is a cancellation policy and that I may be billed for the full rate of the missed appointment if cancelled with less than 24 hours notice. I understand that services rendered are to be paid in full at the completion of the office visit. I understand any guarantor listed above is subject to the same financial terms as

outlined above and that my payment history, account balance, may be disclosed to the guarantor for the purposes of securing payment. I understand if the guarantor, if someone other than myself, is not authorized to receive my medical information unless expressly authorized by me in writing.

Privacy terms: I keep a record of healthcare services provided to you. Applicable state and federal laws protect confidentiality of your medical records and grant you the right to see or obtain a copy of the record we keep. Moreover, if you believe that information in your record is inaccurate, you may also request that we correct or amend that record. I will not disclose your medical information to others unless you direct us to do so or applicable laws authorize us to do so. If you have questions concerning the management of your healthcare information, wish to require about your rights or if you wish to make an appointment to review your medical record, please do so.

I hereby acknowledge that I have read the above information, should I fail to sign this form, I acknowledge that Bedford Natural Medicine has made a good faith effort to obtain my acknowledgement

X _____

Patients signature
date

X _____

Guardian/Representative Signature and relationship
date

Dr. Kristen ODell
(603) 660-9677