Superstition Vitality Center, LLC
312 N. Alma School Rd. Ste #1 Chandler, AZ 85224
Office: 480-857-3187
Fax: 480-857-3467

Patient Demographics

Name: ____
First Name Middle Initial Last Name

DOB: _____/_____/_____ Age: ______ Sex: ______ Marital Status: ________________________

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino Primary Language: _______________________________

Address: ____
Street Address City State Zip Code

Cell Phone: ________________ Home Phone: ________________ Email: ____________________________

We offer reminders and updates through messaging; do you consent to email/texts or both? **Yes** or **No**

Who referred you to our office? ☐ Friend ☐ Google ☐ Yelp ☐ Drive by ☐ Other___________________________

Pharmacy: ____
Name Address or Crossroads

Emergency Contact: ____
Name **Phone** **Relationship**

Insurance Information

Primary Insurance: __________________________________ ID #: ____________ Group ID #: ____________

Primary Card Holder: ☐ Self ☐ Spouse ☐ Parent Effective From: __________ Effective To: __________

Name of Policy Holder: ____ DOB: _____/_____/_____

Copay: $_______________

Secondary Insurance: ______________________________ ID #: ___________ Group ID #: ________

Primary Card Holder: ☐ Self ☐ Spouse ☐ Parent Effective From: __________ Effective To: __________

Name of Policy Holder: ____ DOB: _____/_____/_____

Copay: $_______________

BY SIGNING BELOW, YOU STATE ALL INFORMATION IS UP TO DATE AND CORRECT TO THE BEST OF YOUR KNOWLEDGE. YOU ARE RESPONSIBLE FOR ALL CHARGES AND COPAYS WHICH ARE DUE AT TIME OF SERVICE, YOU ARE RESPONSIBLE FOR ALL COLLECTIONS FEES IF COLLECTIONS ARE NEEDED FOR PAST DUE AMOUNTS APPLIED BY YOUR INSURANCE.
I HEREBY AUTHORIZE SUPERSTITION VITALITY CENTER TO BILL THE ABOVE INSURANCES FOR SERVICES RENDERED TO ME

I HEREBY ASSIGN SUPERSTITION VITALITY CENTER ANY INSURANCE BENEFITS MADE ON MY BEHALF FOR SERVICES PROVIDED BY SUPERSTITION VITALITY CENTER, IF THESE BENEFITS ARE NOT ASSIGNED DIRECTLY TO SUPERSTITION VITALITY CENTER I AGREE TO FORWARD THEM TO SUPERSTITION VITALITY CENTER IMMEDIATELY.
I AUTHORIZED SUPERSTITION VITALITY CENTER TO RELEASE HIPAA INFORMATION IN ACCORDANCE WITH GUIDELINES, EXCEPT AS SPECIFICALLY NOTED. A COPY OF THOSE GUIDELINES/PRIVACY POLICY IS AVAILABLE TO ME IN OFFICE AND HAS BEEN OFFERED TO ME.

SIGNATURE____ DATE_______________

OFFICE VISITS & PAYMENT POLICY

Thank you for choosing us as your care provider. Please review our office and payment policies.

Co-payments, deductibles, and co-insurance: All co-payments, deductibles, and co-insurance must be paid at the time of service.

Late Arrivals: We recognize that your time is valuable, and we do our very best to run on schedule. Patients who arrive more than 15 minutes late may be asked to reschedule their appointment.

Identification and Proof of Insurance: We must obtain your ID card (example driver's license) and current proof of insurance (if you have insurance). All patients must complete our patient information forms to consent for treatment.

Authorization and Release: I authorize payment of insurance benefits directly to the provider or clinic. I authorize my provider to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of medical care regardless of insurance coverage.

____ ________________________________

Signature of patient or responsible party Date