iMed

Maria I Bermudez Fresse, MD

Anti-Aging, Regenerative, Functional, And Metabolic Medicine

imedconcierge@gmail.com www.imedmd.org

REGISTRATION FORM (Complete one form per patient)

Patient Name:(last, first) _____ Date of Birth: _____

Reason for Consultation:: _____ Sex: (m/f) _____

Street Address: _____ City, State, Zip: _____

Email Address: _____ Home Phone: _____

Person Responsible for Patient & Account: _____

Address:(if different from above) _____

Primary Phone:(home, cell, office) _____ Secondary Phone:(home, cell, office) _____

For minors, include both parent's main contact numbers. Mother: _____ Father: _____

Emergency Contact:(other than patient) _____ Relationship to Patient: _____

Financial Responsibilities

I agree to pay for all services and products provided by Maria I. Bermudez-Fresse, M.D. (Preventive Medicine Associates, LLC, DBA iMed) and staff. I acknowledge that this medical practice operates on a "fee-for-service" basis and does not contract with any medical insurance company, nor Medicare or its affilliates. All services/products must be paid for at time they are provided. Upon request, Dr. Bermudez will provide forms that can be submitted to insurance by the responsible party. This does not guarantee there will be any reimbursement. I understand that consultations may be provided either in person, by telephone or email, and will pay the fees for any type of consultation, regardless of whether my insurance company will or will not reimburse me for the fees. If for some reason there is an outstanding balance on my account, I agree to permit Maria I. Bermudez Fresse, M.D. (Preventive Medicine Associates, LLC, DBA iMed) to charge my credit card to clear any outstanding balance.

I have been given the opportunity to review a copy of the HIPAA privacy laws under which Maria I. Bermudez Fresse, M.D. (Preventive Medicine Associates, LLC, DBA iMed) practices. I also have reviewed and am aware of the office policies, and Special Access Program Policies. I understand that policies and fees may be updated without prior notice and that it is my responsibility to verify such policies and fees before services rendered.

I acknowledge that I understand there is a firm 24-hour cancellation policy for established patients (72 hours for initial visits) and I will be responsible for the Doctor's fees for any cancellations or no-shows that happen within 24 hours business day hours (72 hours for initial visits). This applies to scheduled tests and treatments. If the appointment is rescheduled and completed within one week (2 weeks for initial visits), the visit time will be credited to that appointment, minus any deposits, when applicable.

Responsible Party Signature: _____ Date: _____