OPTIMAL HEALTH MEDICAL INSTITUTE PLLC

1542 S. Timesquare Lane Suite 102
Boise, ID 83709
PHONE: (208)495-3688 FAX: (208)475-4924

FULL LEGAL NAME:_____ DATE:_____

SEX: MALE OR FEMALE DOB:_____ MARITAL STATUS: S M D W SS#:_____

HOME PHONE:_____ WORK PHONE:_____ CELL PHONE:_____

PREFERRED CONTACT: HOME WORK CELL

ADDRESS:_____
STREET ADDRESS CITY STATE ZIP CODE

EMPLOYER:_____ OFFICE PHONE #:_____

INSURANCE:_____
INSURANCE NAME ADDRESS CITY STATE ZIP CODE PHONE NUMBER

_____
POLICY NUMBER GROUP NUMBER SUBSCRIBERS EMPLOYER

_____
SUBSCRIBERS NAME RELATIONSHIP TO SUBSCRIBER DOB

SPOUSE NAME:_____ DOB:_____

NAME OF RELATIVE NOT LIVING WITH YOU:_____

RELATIONSHIP:_____ PHONE NUMBER:_____

FAMILY DOCTOR:_____ PHONE NUMBER:_____

ADDRESS:_____
STREET ADDRESS CITY STATE ZIP CODE

CONSENT FOR TREATMENT

I voluntarily consent to care by Optimal Health Medical Institute's (OHMI) employees and contractors. I authorize the medical staff of OHMI to perform laboratory and diagnostic procedures, and administer plan in treating and diagnosing my medical condition. I fully recognize that the treatments I will receive may include conventional as well as integrative, alternative, functional, and preventive therapies. I am aware that the practice of medicine is not an exact science and I understand that no guarantees have been made to me regarding the results of treatments or examinations. OHMI will not be providing emergency care or hospitalized care. The therapy and treatment I receive will compliment the care I receive from my primary care physician and will not replace them.

_____ _____
PATIENT SIGNATURE OR GUARDIAN AND RELATIONSHIP DATE

FINANCIAL POLICY

We participate with Blue Cross, Blue Shield, IPN and several other insurance plans. However, it is your responsibility to obtain any special authorizations that your individual plan might require and to know the requirements and exclusions of your individual plan. Please recognize that our service is to you, not to your insurance company. If your insurance carrier deems services investigational or not medically necessary regardless of contractual agreements you are ultimately responsible for your bill including office visits, medical procedures and labs. We will do our best to work with you and your insurance company. We require a 24 hour cancellation notice. You may be charged a $50 cancellation fee for any appointments cancelled without a 24 hour notice. All outstanding balances (including self-pay patients) are due upon receipt. If balances are not paid upon receipt after 30 days an annual 18% interest rate will accrue. Thank you

_____ _____
PATIENT SIGNATURE OR GUARDIAN AND RELATIONSHIP DATE

HIPAA NOTICE OF PRIVACY PRACTICES

I have read and completely understand the HIPAA notice of privacy practices. Signature below is only acknowledgement that you have received a Notice of our Privacy Practices.

PATIENT SIGNATURE OR GUARDIAN AND RELATIONSHIP:_____ Rev. 08/2017