Alchemy Health Center
Lisa Grossman, DOM, AP, LCSW

Patient Registration & Fee Agreement

Date:____________

Name:____ SS#__________________

Date of Birth:____/_____/_____ Age:_____ Sex: M F

Home address:_________________________________ City/ST:___________________

Zip:_________ Home Phone: (____)_________________ Cell: (____)________________

Email:____________________________ Employer:______________________________

Work Phone: (____)_________________ Position: ______________________________

Emergency Contact: ___________________ Relationship to you:__________________
Phone:_________________________________

Primary Care Physician:____
PCP phone # ____

If Patient is a Minor:
Mother's Name, Address, phone (if different):____

Father's Name, Address, phone (if different): ____

<u>Insurance Information</u>

Insurance Company:_______________________ Insured's name:________________________

Primary ID#:_____________________________ Phone #:______________________________

Secondary ID# ___________________________ Employer: ____________________________

I authorize Lisa Grossman, DOM, AP, LCSW to release any medical information necessary to process my insurance claim(s). I hereby assign all medical benefits to which I am entitled to my practitioner, Lisa Grossman, DOM, AP, LCSW. I understand that I am financially responsible for all charges whether or not they are paid by said insurance. I hereby authorize Lisa Grossman, DOM, AP, LCSW, to administer treatment. I sign this willingly and voluntarily in full understanding, and release Lisa Grossman, DOM, AP, LCSW, from any and all liability. Initial:_________

Cancellation Policy: Please be aware that 24 hours notice is required for any change or cancellation in any future appointments, otherwise, you will be charged directly.

Signature of Patient or responsible party:____

Authorization #:______________________ From:_______________ To:___________ Dx:________________

Number of visits: ________________________