CORNERSTONE INTEGRATIVE MEDICINE

REGISTRATION & FINANCIAL AGREEMENT

EMERGENCY CONTACT NAME RELATIONSHIP	NAME:	DATE OF BIRTH:	AGE	
EMERGENCY CONTACT NAME RELATIONSHIP HOME #: MOBILE #: INSURANCE INFORMATION Please present your insurance card to receptionist upon arrival or before appointment if requested PRIMARY INSURANCE NAME: SECONDARY INSURANCE NAME: NSURANCE AND FINANCIAL DISCLOSURES Your insurance coverage is a contract between you and your insurance company. We will inform you if we are a party to your insurance contract, and will intend you claims according to our agreement with the insurance company. We will not become involved in disputes between you and your insurance company reparating deductibles, on-payments, covered charges, etc. Verification of insurance coverage is our responsibility. If your insurance pair nequires per-authorization, it is the responsibility of you and your primary care provider to obtain pre-authorization for you to be seen by one of our providers. Otherwise, the charges incurred may become an out-opecket expense to you. When we are contracted why our insurance coverage is to you. When we are a contracted why our insurance prompting to providers. Otherwise, the charges incurred may become an out-opecket expense to you. When we are contracted why our insurance prompting to put responsibility. Final payment should be submitted in a timely manner (within 30 days from receipt of insurance payment/EGB or Date of Service). AUTHORIZATION TO RELEASE BENEFITS, PAYMENTS ANDOR MEDICAL RECORDS Insuest that payment of allowed andor authorized benefits be made on in we health to Comerstone Integrative Medicine for any services provided. I also authorize Comerstone Integrative Medicine to release any information from my medical record to the insurance company for payment of claim submitted. PRIVACY PRACTICES ACKNOWLEDGEMENT (HIPPA) In the event your check payment is returned by your financial institution, you will be responsible for the financial institution fee. CANCELLATION AND/OR MISSED APPOINTMENT FEES We require a 24 hour notice of appointment cancellations, otherwise a \$ 50.00 late cancellation and fo	ADDRESS:	DI	DRIVER'S LICENSE	
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	Name:	Date:		

If Signing on behalf of the patient, state name and relationship: