

HELIOS INTEGRATED MEDICINE
4150 Darley Avenue Suite 1
Boulder, CO 80305

PATIENT REGISTRATION

Patient Information:

Date: ____/____/____

Name _____

Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ - _____ Cell Phone (____) - _____ - _____ Fax (____) - _____ - _____

Employer _____ Work Phone (____) - _____ - _____ Email _____

(Is it OK to leave a voice mail message at these numbers? YES _____ NO _____)

Date of Birth ____/____/____ Age _____ Gender (M/F) Social Security # _____ - _____ - _____

RESPONSIBLE PARTY: (billing responsibility)

Name _____ Relationship to Patient: Self Spouse Parent Other _____

Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ - _____ Work Phone(____) _____ - _____ Employer _____

Credit Card Number: _____ - _____ - _____ Exp: ____/____

WHO TO NOTIFY IN AN EMERGENCY:

Name _____ Relationship to Patient: Self Spouse Parent Other _____

Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ - _____ Work Phone(____) _____ - _____ Employer _____

- I understand that I am ultimately responsible for payment for services and/or supplies.
- I understand that I am responsible for understanding my individual insurance coverage.
- I will make any disputes of charges at the time of service. All charges will remain as charged on the day of service.
- I understand that I WILL be charged a fee for appointments that are not cancelled within 24 hours.
- I understand that I WILL be charged a maximum fee of \$ 20.00 for each returned check.

SIGNATURE: _____ DATE _____

Welcome!