Dr. Renee Mammone, N.D. ***Naturopathic & Acupuncture Health Center*** ***John Mammone, L.Ac.***
Dr. Marie Mammone, N.D. ***274 Silas Deane Hwy*** ***Licensed Acupuncturist***
Naturopathic Physicians ***Wethersfield, CT 06109***

New Patient Information

Patient's Name_____Sex M F Date of Birth_____

Address_____Phone_____cell_____

City_____State_____Zip code_____

Email: _____

Insured's Information:

Name of Insured_____Insured's Date of Birth_____

Relationship to Patient: Self_____Spouse_____Parent_____Guardian_____

Name of Insurance Company_____

Group#_____ID#_____

Co-payment: _____ Co-insurance: _____ Deductible:_____

CANCELLATION POLICY

If you are not able to keep your scheduled appointment, please notify us within 48 hours of the appointment. There is no charge if an appointment is cancelled within 48 hours during Monday - Friday Business hours of 9am -6pm. A cancellation with less than 48 hours notice does not allow enough time for other interested patients to be scheduled, and is a great inconvenience for our center. Late cancellations will be billed at full office visit cost and you will be invoiced.

PHONE/EMAIL SUPPORT VISIT

Both phone and email supports are available as another option for a visit. Phone visits and email support is at the discretion of Dr. Mammone. Please understand if this service is not appropriate for care Dr. Mammone will let you know. Complimentary 10 minutes phone or email support follow up within week of visit to clarify anything already discussed. You must have a credit card on file for phone/email support. Remember calls & emails are only answered during business hours.

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FINANCIAL RESPONSIBILITY and POLICY STATEMENT:

I hereby assign to Dr. Mammone, ND any medical benefits for services rendered to which I am entitle. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges, whether or not paid by said insurance. Co-payments, co-insurance and deductibles are due at the time of service. In case of default of payment of the balance; any collection costs and legal fees incurred to collect this amount will be added to balance.

Authorization of Release of Information: I hereby authorized Dr. Mammone, ND to release all information necessary to secure payment. For your convenience, we accept cash, personal checks, credit cards, and FSA/HSA cards.

Acknowledgement of Forms and Policies:

Initial: _____ I have read a copy of Notice of Privacy Practices

Initial: _____ I have read a copy of the Informed Consent Form

Initial: _____ I have read a copy of Email Consent Form
Initial: _____I would like to receive interesting health information and/or newsletters

Patient Signature_____Date _____

I appreciate you supporting my business.