



Welcome form

Patient Name _____ e-mail _____
last, first m

Patient Address _____ phone _____

City _____ state _____ zip _____ phone _____

Patient DOB ____/____/____

Patient Driver's license# _____ state _____ s.s.n # _____

Insured/Guardian Name _____ & _____

DOB: _____ insurance _____

Emergency contact info

Name _____ phone _____

Consent for treatment:

I authorize the practitioners and clinical staff of One Family, LLC to render whatever services they deem necessary for the care of myself and/or my baby. I understand it is my obligation to ask questions and be fully informed of all procedures performed. I agree to assume all financial obligations, regardless of insurance coverage, incurred for such care.

X _____/_____/_____

Sign Date

Payment agreement & Assignment of Benefits:

I understand my providers are obligated to chart, code and generate fees for all services rendered. If paying with insurance, I am responsible for providing a copy of my current insurance information to the office. Insurance information may be required before services are rendered. I hereby authorize One Family, LLC all payments for medical services rendered to my dependants and myself.

X _____/_____/_____

Sign Date

A list of All fee schedules and services available, is available upon request.

