Patient Registration

Patient Information

Last Name: _____First Name: _____ Middle Name: _____
Date of Birth: _____ Sex:_____ Other names that records may be kept under:_____
Address: _____ City: _____ State: _____ Zip Code: _____
Email Address: _____ Would you like to subscribe to our online newsletter? **Y❒ N❒**
Phone: Home:(___)_____ Cell:(___)_____ Work: (___)_____
May we leave confidential voice-mail messages for you at any of the above numbers? ❒Yes ❒No
Please specify: ___ **Home** _____**Cell** _____**Work**
Emergency Contact Name & Relationship:_____ Contact's Phone #:(___)_____
How did you hear about Dr. Alexandria?_____

For Minors - Financial Responsibility (Guarantor) – Parent and/or Guardian

Last Name: _____ First Name: _____ Middle Name: _____
Date of Birth: _____ Sex:_____ Other names that records may be kept under:_____
Address: _____ City: _____ State: _____ Zip Code: _____
Mother's Name (minors only):_____ Father's Name (minors only):_____

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient/client and that I am subject to all financial terms listed below.

X_____ _____
Guarantor's Signature **Date**

Terms of Admission

Financial Terms: I understand that if I am responsible for all charges whether or not they are covered by my insurance. I understand that payment for services and/or supplements and products are due in full at the time of service and/or purchase. I understand that a a $30.00 fee will be charged for returned checks (non-sufficient funds), in addition if payment is not received within 30 days finance charges will begin accruing at a rate of 1.5% per month. I further understand that excessively overdue accounts will be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that any guarantor listed above is subject to the same financial terms as outlined in this paragraph and that my payment history, account balance and due dates may be disclosed to the guarantor for the purposes of securing payment. I understand that the guarantor, if someone other than myself, is not authorized to receive my medical information unless expressly authorized by me in writing.

Privacy Terms: We keep a record of healthcare services we provide you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the record we keep. Moreover, if you believe that information in your record is inaccurate, you may also request that we correct or amend that record. We will not disclose your medical information to others unless you direct us to do so or applicable laws authorize or compel us to do so, Karsten Alexandria, N.D. and/or Purple Sage Center, Inc. is required to provide you, at your request, with a copy of its Notice of Privacy Practices and to obtain written acknowledgement that you have reviewed it. The notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning the management of your healthcare information at our clinic, wish to inquire about your rights or if you wish to schedule an appointment to view your medical record, please call our medical records office at: 602.938.8200

I hereby acknowledge that I have reviewed a copy of Karsten Alexandria N.D. and/or Purple Sage Center, Inc., Notice of Privacy Practices. Should I fail to sign this form, I acknowledge that Karsten Alexandria, N.D. and/or Purple Sage Center, Inc. has made a good faith effort to obtain my acknowledgement.

X_____ _____
Patient's Signature **Date**

X_____ _____
Guardian's Signature **Date**

Purple Sage Center, Inc.
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602.938.8200