Integrative Healthcare Providers
2800 S. State St. Ste. 215
Ann Arbor, MI 48104
Phone: 734-547-3990
Fax: 734-547-3980

Amy F. Saunders, MD
Amanda Kaufman, MD
Elisa Picken, MD
Sean Zager, MD
Susannah Parke, DO
Brenna Reichman, NP
Robert Piper, MSW

Welcome to our Practice!

Please find enclosed our Patient Registration Forms.

Make sure to bring them in completed the day of your visit.

We are required to make a copy of your insurance card(s) and photo identification at the time of your first appointment. Therefore, if possible, please arrive 15 minutes early for your first appointment.
It is required that you provide one business day notice to reschedule or cancel an appointment.

We look forward to working with you!

New Patient Registration

Patient Information:

Legal Name: _____ Preferred Name: _____
First MI Last
Date of Birth:_____ Legal Sex: □ F □ M Gender: □ F □ M □ Other: _____
Street Address: _____ Apt. #:_____
City/State/Zip: _____
Home Phone: (____) _____-_____ Cell: (____) _____ - _____ Email:_____

Preferred Pharmacy:_____ Phone: (_____)_____-_____

Emergency contact :_____ Phone: (_____)_____-_____

If patient is a minor: Parent #1: _____ Phone: (_____)_____-_____
Parent #2:_____ Phone: (_____)_____-_____

Insurance information:

Primary Insurance Company:_____ Insurance Phone: (_____) _____-_____
Policy Holder Name: _____ Date of Birth:_____
Policy #: _____ Group #: _____ Relationship: _____

Secondary Insurance Company: _____ Insurance Phone: (_____) _____-_____
Policy Holder Name: _____ Date of Birth:_____
Policy #: _____ Group #: _____ Relationship: _____

Do you authorize Integrative Healthcare Providers to contact you via phone, text and email for appointment reminders and for follow up for your treatment and testing? Yes OR **No**

Please indicate any exclusions:_____

Choose one preferred method for receiving appointment reminders?
Text OR **Email**

I authorize IHCP to call or send SMS text messages to my cell phone number to provide appointment reminders. If I do not want to receive calls or SMS text messages, I can unsubscribe by sending an email to office@ihcpaa.com or by calling us at 734-547-3990. I understand standard text messaging rates and fees from my mobile carrier may apply.

Signature: _____ Date: _____

Consent to Treatment:

I consent to treatment by Integrative Healthcare Providers physicians and ancillary staff. This consent includes diagnostic examinations, procedures and treatment, including medications provided under the instructions of the physicians. This consent also includes x-rays, laboratory tests, and other diagnostic tests deemed appropriate by the physicians.

I understand that more than one individual provider may be involved in my care, and that for this purpose my protected health information will be available to all such practice personnel.

I understand that some procedures, including but not limited to osteopathic manipulation, are "hands-on" treatments. **If you have any questions or concerns, or feel uncomfortable at any time during your treatment, please let us know.** I also understand that the practice of medicine is not an exact science, and practitioners can make no assurances as to results.

I authorize Integrative Healthcare Providers and affiliated Clinician/Physicians to treat me (my child) and use my (my child's) personal health information for continuity of health care purposes.

Name: _____
Signature: _____ Date_____
(parent signature if patient is a minor)

HIPAA Consent:

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do not agree then you are bound to abide by such restrictions.

I understand that you may revoke this consent in writing at any time, except to the extent that you have taken action relying on the consent.

Name: _____
Signature: _____ Date_____
(parent signature if patient is a minor)

Cancellation/No Show Policy:

We understand there may be times when you may miss an appointment due to emergencies or unforeseen obligations to work or family. We request you call with one business day notice for canceling of an appointment to avoid missed-appointment **"no-show" fee of $75.00,** this will be applied to any/each appointment missed without reasonable cause and without one business day notice. Depending on the circumstances, we may waive the fee for the first missed appointment, at the practitioner's discretion. I also understand that if I "no-show" for multiple appointments, or cancel multiple consecutive appointments, I *may* be discharged from care. In that case, Dr. Saunders will notify you in writing should you be discharged from care. I have read and understand the above **Cancellation/No Show Policy,** and I agree to the terms described:

Name: _____
Signature: _____ Date_____
(parent signature if patient is a minor)

Supplement Policy:

Our practice carries high quality supplements that are manufactured by companies of the highest integrity in the industry. While we trust their quality, we are not legally responsible for any manufacturing errors on their part, nor for potential interactions that may occur with supplements we recommend and others you may choose to take without informing us. We realize that you can get these products over the counter elsewhere and do not require you to purchase supplements from our office. Your care is not affected by your decision not to purchase here. You have the right to ask questions and have them answered to your satisfaction regarding the use and purpose of all suggested supplements.

Name: _____
Signature: _____ Date_____
(parent signature if patient is minor)

Non-covered Benefit Release:

I, _____, understand that I may request a service that may not be a covered benefit as determined by my medical insurance carrier. I acknowledge that my insurance carrier determines which services are deemed medically necessary and covered under each plan. Integrative Healthcare Providers will attempt to bill my insurance for the service provided, but I acknowledge that I am responsible for any balance.

Name: _____
Signature: _____ Date_____
(parent signature if patient is minor)