Vitality Health & Wellness
815 4th Street
Miami Beach, FL 33139
Ph: 305-466-1100 Fax: 305-466-1160
www.vitalitywellness.com

Registration

Patient Information

____ _______________
(First, Middle, Last Name) *(Date of Birth)*

_______________________________ _______________________________
(Address) *(City, State, Zip Code)*

_______________ _______________ _______________
(Home Telephone Number) *(Work Telephone Number)* *(Social Security Number)*

_______________________________ _______________________________
(Cell Phone Number) *(Email Address – Please Print Clearly)*

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed
Sex: ☐Male ☐Female
Employment Status: ☐Employed ☐ Part-time Student ☐ Full-time Student ☐ Other

Employment Information

_______________________ _______________________________
(Occupation) *(Employer)*

_______________________________ _______________________
(Address) *(City, State, Zip)*

Responsible Person (If Applicable)

_______________________________ ___________ _______________
(Name or Names) *(Date of Birth)* *(Relationship to Patient)*

_______________________________ _______________________
(Address) *(City, State, Zip Code)*

_______________ _______________ _______________
(Phone Number) *(Social Security Number)* *(Occupation)*

_______________________________ _______________________
(Employer) *(Employer Phone Number)*

Relative to Contact in Case of Emergency (Not Living in Home of Patient)

_______________________________ ___________ _______________
(Name) *(Phone Number)* *(Relationship to Patient)*

_______________________________ _______________________
(Address) *(City, State, Zip Code)*

Insurance Information

_______________________________ _______________ _______________
(Name of Insured) *(Date of Birth)* *(Relationship to Patient)*

_______________________________ _______________ _______________
(Insurance Company) *(Group Number)* *(ID Number)*

_______________________________ _______________________________
(Address) *(City, State, Zip Code)*

How were you referred to our office?

	Please print the name of your source below.
☐ **By an Attorney** ☐ **By a Doctor** ☐ **By a Patient** ☐ **Other**	_______________________________

Consent to Treatment

I voluntarily consent to receive medical and health care services that may include diagnostic procedures examinations and treatment.

Financial Responsibility and Assignment of Benefits

I agree to pay all charges for medical and health care services at Vitality Health & Wellness.

I understand that the doctors here are not "in-network providers" with any insurance companies and that the office operates as a "fee-for-service" office and that all services must be paid for at the time of the visit. I understand that I will be paying for "contact" with the doctor whether by email, phone or in-person; irregardless of whether my insurance offers reimbursement for this type of contact (charge for "non-local" contact will be at the discretion of the doctor and will be charged at prevailing rates; however, in most cases this will not apply for urgent phone contact that lasts less than five minutes). I agree to allow Vitality Health & Wellness to charge my credit card for any outstanding balances that may occur from time to time.

I also understand that the office has a **24-hour cancellation policy** and that it is **strictly enforced** and does not include weekends or holidays (i.e. an appointment that is scheduled for Monday morning at 10 am must be canceled by 10 am on Friday morning in order to avoid a cancellation charge). Cancellation fees will be based upon the amount of time that is scheduled for the office visit. The office will attempt to contact you as a **courtesy** prior to your scheduled appointment time as a reminder.

Vitality Health & Wellness complies with HIPAA for privacy rules and I have seen a copy of the policies that this office operates under.

I certify that I have read this form and understand its contents.

_______________________________ _______________
(Patient or Other Legally Authorized Person) *(Date)*