WATERSHED WELLNESS

_____
Legal Name (First Middle Last)

_____
Preferred Name (Nickname)

_____
Street Address

_____ _____ _____
City State Zip code

_____ _____
Phone number Email address

_____ _____
Date of Birth Marital Status Preferred gender + pronoun

Do you prefer phone or email contact? _____

Would you like to be added to our email newsletter list? You can opt out anytime. [ ] Yes [ ] No

_____/_____/_____
Occupation or – if you prefer – how do you spend your days? Employer? Number of hours per week?

_____
Emergency contact name Emergency contact relationship

_____
Emergency contact cell phone number Emergency contact home phone number

By signing below, I acknowledge that I am financially responsible for all charges.
I understand that payment is due upon receipt of treatment. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize Watershed Wellness to release information necessary to secure payment to insurance billers, insurance companies and other related entities. I authorize the release of any medical or other information necessary to the process of this claim. I also authorize payment of government benefits either to myself or to the party who accepts assignment in Box 27 of the CMS 1500 form on which claims for me are submitted. I understand that a Missed Appointment Fee of $25.00 will be charged for missed appointments or late cancellations.

_____ _____
Client or Authorized Person's Signature Date of Signature

WATERSHED WELLNESS

Name_____Date of Birth_____

What is the main reason for your visit today?

_____

What are you chiefly hoping to address?

_____

Are you currently receiving healthcare? [ ] Yes [ ] No.

If yes, from whom? _____

For what reason? _____

Have you had any recent hospitalizations or surgeries?

_____

Do you have any major medical conditions that you are currently under treatment for?

_____

Please list all medication and supplements below:

Medication or Supplement	Dosage	Frequency