CLIENT REGISTRATION FORM

Legal Name (First Middle Last)

Preferred Name / Nickname / Other names

Street Address (if none, say none or n/a)

City State Zip code

Phone number Email address

Date of Birth Marital Status Pronouns

Do you prefer phone or email contact? ______

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

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.

Client or Authorized Person's Signature Date of Signature

Name___________________________Date of Birth___________________________

What is the main reason for your visit today? What are you chiefly hoping to address?

____

____

Are you receiving healthcare outside of Watershed Wellness? [ ] Yes [ ] No.

Practitioner names & specialties:

____

____

Have you had hospitalizations or surgeries in the last 5 years?

____

Have you been in a car accident in the last 30 days?

____

Please list pharmaceuticals and unusual supplements below (or use separate sheet)