reboot center
FOR INNOVATIVE MEDICINE™

P 360 331 2464
F 866 277 7173

5492 MYRTLE AVE | PO BOX 554
FREELAND WA 98249

INFO@REBOOTCENTER.COM
REBOOTCENTER.COM

ADULT DEMOGRAPHIC & BILLING INFORMATION

I. Patient Information

Full name: _____ Date of birth: _____/_____/_____ Gender: _____

Other past or present given or used names:_____

Marital status: Single Married Partner /Significant Other Widowed Separated Divorced

Mailing address:

_____

City: _____ State: _____ Zip: _____

Please designate a primary email address and **primary phone number** at which we can leave confidential communications regarding appointments, your health care, and other important information:

Confidential email address*: _____ **Confidential phone number:** _____

*Please note: Unless specifically requested otherwise, appointment confirmations and other confidential health information will be communicated to your **designated confidential email address**.

Secondary email: _____ Home phone number: _____

Work phone number: _____ Mobile phone number: _____

Employer: _____ Occupation: _____

Whom may we thank for referring you? _____

Who are your health care providers? _____

Would you like a Reboot Center provider to act as your Primary Care Provider? Yes No

II. Emergency Contact (not residing at the same address)

Name: _____ Relationship: _____

Home phone: _____ Work phone: _____ Mobile:_____

III. Billing Information

Does your insurance plan have naturopathic and alternative medicine benefits? Yes No

Does the plan require that you designate a PCP? Yes No If yes, please take the necessary steps to list Dr. Schiavone-Ruthensteiner / Dr. Williams with your insurance carrier so that we can bill according to your contract.

Is a referral required in order to receive coverage? Yes No If yes, list referring provider: _____

Primary Care Provider (if not a Reboot Center provider): _____Clinic phone: (_____)_____

PCP Clinic address: _____ City: _____ State: _____ Zip: _____

Primary Insurance Company & Plan Name:_____

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ID#: _____ Group/Policy#: _____ Co-pay: _____

Name of policy holder _____ Policy holder's date of birth: _____/_____/_____

Policy holder's address: _____

Relationship of policy holder to patient: _____ Policy holder's gender: _____

Is your Primary Insurance Policy a (*circle*): POS PPO EPO HMO Other: _____

Secondary Insurance Company & Plan Name:_____

ID#: _____ Group/Policy#: _____ Co-pay: _____

Name of policy holder _____ Policy holder's date of birth: _____/_____/_____

Policy holder's address: _____

Relationship of policy holder to patient: _____Policy holder's gender: _____

Is your Secondary Insurance Policy a (*circle*): POS PPO EPO HMO Other:_____

Guarantor Information

*If you are the patient and financially responsible for your own account, please write "**self**" and sign at the bottom. If someone other than the patient is responsible for the account, he/she must complete in full and sign.*

Guarantor's last name: _____ Guarantor's first name:_____

Date of birth (required): _____/_____/_____ Gender: _____

Mailing address: _____

Home phone number: _____ Mobile number: _____

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient. I understand that all co-pays are due at the time of service and that I am financially responsible for all charges whether or not they are paid by insurance. I understand that finance charges will begin accruing on accounts that are 60 days past due for payment at a rate of 2% 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 some third-party payers may require that some medical information, including copies of treatment notes, be submitted along with requests for payment. I hereby authorize Reboot Center to release all medical information necessary to secure payment of benefits from the third-party payers specified above, and I authorize the use of this signature on all related submissions. I understand that this information may include medical information related to drug and alcohol abuse, STDs, HIV/AIDS and mental health. I understand that this authorization shall remain valid without expiration unless expressly revoked by me in writing.

Guarantor's Signature: _____ **Today's date:** _____

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Non-Covered Service/Supply Billing Agreement

The services and/or supplies listed below may be classified by your medical insurance company as not medically necessary and/or investigational. These services and/or supplies are not insurance reimbursable; therefore, if your Reboot Center provider incorporates one or more of these procedures, services or supplies into your treatment program, you must pay for them at time of service and not seek reimbursement from your insurance company. If Reboot Center is billing your plan for office visits on your behalf, your plan contract may stipulate a visit Copay/CoInsurance payment in addition to these service/supply charges.

This is not a complete list of non-covered services, as your insurance company may designate other services and supplies as non-covered without providing notice to Reboot Center.

- Nutritional Supplements
- Functional Blood Assessment
- FBA 24-hr Incubation
- Intramuscular Injections
- Intravenous Injections
- Neural Therapy
- Far Infrared Sauna
- BioImpedance Analysis
- Laser Therapy
- Scenar Therapy
- Local Infrared Therapy
- Liquid Mineral Testing
- Allergy Skin Scratch Testing
- Preventive/Standard Laboratory Tests
- Integrative/Specialty Laboratory Tests

I, _____ agree to pay for any services and/or supplies that my insurance company deems not medically necessary or investigational and not to seek reimbursement for these supplies/services from my insurance.

Signature: _____ **Today's date:** _____