NEW PATIENT INFORMATION and CONSENT FORM

Form and Function Osteopathic Medicine
Kris Sornberger Osteopathic Healthcare, PLLC
One Cumberland Place
Suite 112
Bangor ME 04401
Phone: 207-307-0816
Fax: 207-637-1072

Date:_____________

Patient's Name__________________________________ M___ F___ Birthdate______________Age______

If patient is a minor or has guardianship, Name of person filing out form: _______________________________

Patient's address: ____

City________________________________State_____________________Zip______________________________

Email: ____

Phone: home_________________ cell__________________ ***Text appointment reminders: (circle) YES NO***

Social: Single___ Married___ Other___

Occupation: ____

Employer: ____

Primary Care Physician: ________________________ Location: clinic and town/state _______________________

Emergency Contact Info: Name: _______________________ Relationship: ____________ Phone: ___________

Insurance coverage primary name__________________ ID #__________________ Group #______________

Insurance coverage secondary _____________________ ID #__________________ Group #________________

Work Related Injury: **YES NO** Claim #___________Date of Injury__________ Insurance carrier_____________

Motor Vehicle Accident Injury:**YES NO** Claim #__________Date of Accident_________ Insurance carrier______

I understand and agree to the following:

I understand that the Medical Practice accepts *all forms of insurance payment*. However, payment for services rendered at the Practice is solely my responsibility, regardless of any insurance coverage I may have. I am financially responsible for payments that are denied or rejected (after the Practice has made all good-faith attempts to obtain payment from the insurance company) by the insurance company and for those charges not covered by insurance policy benefits, such as deductibles, co-insurance, and co-pays.

I authorize the release of any medical records and/or any other pertinent information necessary to obtain payment for services to any insurance organizations or its affiliates, and authorize release of records to any medical review agencies or other agencies as required.

I voluntarily and knowingly consent to and request any type of outpatient treatment, which may include Osteopathic Manipulation Therapy (OMT) and other types of medical treatments deemed appropriate by the treating physician. I understand that such services are to be performed by the attending physician. I understand that OMT is a hands-on therapy that has risks and benefits. Some risks are increased pain or soreness after the OMT is completed. I have verbally consented to have OMT preformed as a non-invasive, conservative therapy to treat my acute and chronic conditions.

I understand that Form and Function Osteopathic Medicine, Kris Sornberger, DO
is not a Primary Care Provider (PCP) and that my visit with said doctor is for specialty services only.

____ _____________

Signature of patient, parent or guardian **Date**

Receipt of Notice of Privacy Practices Written Acknowledgement Form

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I am a patient or parent or guardian at Form and Function Osteopathic Medicine Practice. I hereby acknowledge receiving and reading of Form and Function Osteopathic Medicine's Notice of Privacy Practices information.

Name :____

Signature: ____ Date: ___________

Relationship (check one) Patient: _______ Parent:_______ Legal Guardian:_____

Authorization of Communication Via Email and/or Text Message

I authorize Form and Function Osteopathic Medicine to communicate with me via:

circle one or both: email text

for the purpose of confirming appointments, rescheduling appointments, and any other general pertinent information that the medical practice may need to inform me of. I also consent to receiving via email or text receipts for payment for any services rendered at The Practice. I understand that email and text may not be a secure method of communication. I understand that I may opt out of emailed or text communication any time.

____ Date: ____________

Signature