

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 and text: 207-307-0816
Fax: 207-433-1050
email: FormFunctionOsteopathic@gmail.com

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 : _____

PCP Location: clinic and town/state _____

Emergency Contact Info: Name: _____ Relationship: _____ Phone: _____

Insurance coverage primary _____ 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. Osteopathic Manipulation is considered a therapeutic procedure and can result in a second charge to the insurance, in addition to the office visit charge. There may be two separate charges to the insurance associated with your visit today.

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 performed 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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Kris Sornberger Osteopathic Healthcare, PLLC
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Bangor ME 04401
Phone: 207-307-0816

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.

Signature Date: _____