Patient Intake/Consent to Payment

Name: **Date of Birth:**

Address: **Postal Code:**

Home Phone: **Cell:**

E-Mail Address: **MCP Number:**

Place of Employment: **Occupation:**

Next of Kin: **Emergency Contact #**

Family Doctor: **Phone:**

Referring Doctor: **Phone:**

Presenting problem(s):
_____

How did you hear about this clinic?

Insurance Company:

Policy Number: **ID:**

On discharge would you like us to send a report to your doctor? **Yes __** **No__**

• Consent to Pay:
I understand that I am responsible for the payment of any fee or surcharge for each treatment unless paid by my medical plan, other insurance company or agency.

I understand that I am responsible to keep scheduled appointments and that I will be charged $25.00 for appointments cancelled on short notice (less than 24 hours) and that I will be charged the full treatment fee if I miss a scheduled appointment without prior cancellation by phone or in person.

• Consent to Release of Health Information:
I hereby authorize all providers at Avalon Laser Health Clinic to release data or documentation regarding my medical condition and treatment to referring Physicians. Information to lawyers and insurers will be released upon request when accompanied by my written authorization

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Patient Signature: **Date:**