Desert Wellness Center

Family Medicine Using Modern Science and Ancient Wisdom

Patient Information & Agreement

Name:_____ Date Of Birth:_____

Address:_____ Home Phone:_____

City, State, Zip:_____ Cell Phone:_____

Email:_____

How did you hear about us? (circle) Online / Event / Drive By / Physician / Current Patient / Other: _____

In the Event of an Emergency, Please Contact:_____

Relationship to the Patient:_____ Phone Number:_____

Consent to Treat:

I consent to services rendered and provided to me by the attending physician and licensed professionals at Desert Wellness Center, participating in or consulting about my care. I may be given additional consent forms for specific therapies that contain more information. My practitioner will additionally discuss all treatments with me, and answer questions as needed.

_____ _____

Patient's/Guardian's Signature Date

Financial Policy:

Thank you for selecting Desert Wellness Center for your health care needs. We are honored to be of service to you and your family. Please be advised that payment for all services will be due at the time services are rendered. If you should desire to submit costs associated with your care to your insurance company, Desert Wellness Center will provide you with the necessary codes, but Desert Wellness Center does not guarantee that your insurance will reimburse any of those expenses. **We do not offer any refund on deposits or payments made for any services or lab kits**. Please be aware labs are not covered by Medicare/Medicaid, AHCCCS and HMO insurances when ordered by a Naturopathic Physician. If you choose to use your insurance you will be responsible for any bill received to us.

_____ _____

Patient's/Guardian's Signature Date

Cancellation Policy:

We have a 24-hour cancellation/reschedule policy. If you do not call Desert Wellness Center at least 24-hours prior to your scheduled appointment time to cancel or reschedule, you will be charged a $25 fee for the appointment.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs. I have read and understand all of the above and have agreed to these statements. By signing below, I understand and agree to the patient payment and cancellation policy. I guarantee payment of all charges incurred as a patient of Desert Wellness Center.

_____ _____

Patient's/Guardian's Signature Date

I acknowledge that I have received a copy of Desert Wellness Center's Notice of Privacy Practices.

_____ _____

Patient's or Guardian's Signature Date

2141 E. Warner Rd.
Tempe, AZ 85284

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Fax: (480) 304-3208

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