Scala Naturae
INTEGRATIVE HEALTH

1. Patient Registration & Demographics

Legal Name

Preferred Name

Date of Birth

Sex Assigned at Birth

Gender Identity

Pronouns

Address

City/State/ZIP

Mobile Phone

Alternate Phone

Email

Preferred Language

Emergency Contact

Emergency Contact Phone

Preferred Pharmacy

Pharmacy Phone

Insurance / Medicare / Medicaid

Primary Insurance

Member ID

Group Number

Medicare ID

Medicaid ID

Policyholder Name

Electronic Signature:

Date:

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16. Financial Policy

Patients are responsible for applicable copayments, deductibles, coinsurance, self-pay fees, non-covered services, and balances not paid by insurance. Payment may be due at the time of service unless prior arrangements are made. Missed appointments or late cancellations may be subject to a no-show or cancellation fee. Insurance benefits are not a guarantee of payment.

- I understand my financial responsibility.
- I understand insurance may not cover all services.
- I understand cancellation/no-show policies may apply.
- I agree to provide accurate insurance information.

Electronic Signature: Date: