Sojourns
COMMUNITY HEALTH CLINIC

General Information

Legal Name: _____ (Last) _____ (First) _____ (Middle)

Preferred Name (if different): _____ (Last) _____ (First) _____ (Middle)

Mailing Address: _____

_____ (City) _____ (State) _____ (Zip Code)

Physical Address (if different): _____

_____ (City) _____ (State) _____ (Zip Code)

Primary Phone Number: _____ OK for Sojourns to leave a message? ○ Yes ○ No

Cell Phone: _____ Work Phone: _____ OK to call at work? ○ Yes ○ No

Age: _____ Date of Birth: _____ Gender: _____ Preferred Pronouns: _____

DEMOGRAPHIC INFORMATION:

Patient Race: ☐ Native American ☐ Asian ☐ Black ☐ White ☐ Pacific Islander ☐ Declined ☐ Other: _____

Is Patient Latino/Hispanic? ○ Yes ○ No ○ Declined

Email: _____ (for Sojourns' outreach efforts and schedule reminders)

Name and ages of those living with you: _____

Primary Care Physician: _____ Dentist: _____

Current Insurance Carrier: _____ Individual/Subscriber ID#: _____

Primary Subscriber Name: _____ Birth Date: _____

Address of Subscriber (if different from patient): _____

In Case of Emergency, Notify: _____ Phone Number: _____

Who Referred You? _____

AUTHORIZATION TO RELEASE INFORMATION

☐ I hereby authorize the release of any medical information necessary in providing follow-up reports with a referring physician or in the processing of my insurance claim.

By typing my name into this box, I hereby agree that this action constitutes my electronic signature.

Patient Signature: _____ Date _____

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PATIENT FINANCIAL AGREEMENT

I accept full financial responsibility for services rendered at Sojourns Community Health Clinic. I understand that it is my responsibility to understand and be aware of the benefits available to me under my insurance plan*. I am aware that my insurance company may not cover all services received or reimburse Sojourns for the full amount billed, and that I am financially responsible for any unpaid balances, co-insurance, co-payments**, deductibles, and charges for un-covered services. I authorize direct payment of medical benefits from my insurance carrier to Sojourns Community Health Clinic for services rendered. Most insurance companies require a referral or prescription from Primary Care Physicians for many of the services we offer, and if I choose to receive these services without the required referral, I understand that I am responsible any costs incurred.

**A summary of your insurance benefits is available to you by calling the member services number on the back of your insurance card.*
*** If **VT Medicaid** is your secondary insurance, they will cover deductibles and co-insurance, but they **will not cover co-payments.***

FEES & SERVICES

Payment for non-covered services, deductibles, and apothecary items is due at the time of service. In consideration of reduced administrative costs, Sojourns offers a time-of-service discount for payment received at the time of service for non-billable services. Please note that this discount is only available to individuals who have no outstanding balances and who settle all bills at check-out. The time-of-service discount does not apply to apothecary items. We accept cash, check, MasterCard, and Visa. We are not able to accept post-dated checks.

Sojourns will send out monthly statements reflecting patient responsible balances. If you are having difficulty with payment, it is important to contact us to create a payment plan that allows us to continue to work with you. Failure to make payment arrangements for balances older than 90 days may result in termination of care at Sojourns.

MISSED & LATE CANCELLATION APPOINTMENT POLICIES

Sojourns requires a 24-hour notice of any cancellations in order to make these appointments available to others who might need them. A *missed* appointment without prior notification will be billed as follows: $60 for an hour, $40 for a 1/2-hour, and $20 for a 1/4-hour. A *late cancellation appointment* (less than 24 hour notice) will be billed at $15.00 for a 1/4-hour appointment and $35 for all other appointments. Please note that these charges are always the responsibility of the patient and cannot be billed to any insurance company.

CHIROPRACTIC INITIAL EVALUATIONS & WELLNESS CARE

Not all insurance companies reimburse for Physical Exams/Initial Evaluations performed by a chiropractor. If your chiropractor feels that the Initial Evaluation is necessary to effectively assess your condition and determine a treatment plan, and this service is not covered by your insurance, payment will be due at the time of service.

Many insurance companies (including Medicare) only cover chiropractic care for treatment of an acute injury or incident and do not cover wellness or maintenance care. If you choose to receive chiropractic care that is not covered by your insurance policy, payment will be due at the time of service.

COLLABORATION POLICY

We are dedicated to ensuring you receive appropriate and timely care. In the unlikely event that the practitioner you have scheduled with is unexpectedly unavailable, we will make every effort to keep your appointment by scheduling you with another practitioner who has similar skills and experience. As part of our health care model, our practitioners actively collaborate and are familiar with each other's work and protocols. Additionally, we make internal referrals and substitutions while keeping in mind insurance limitations or specifications.

☐ **I have read and understand the above stated policies.**

By typing my name into this box, I hereby agree that this action constitutes my electronic signature.

Patient Signature: _____ Date _____