REGISTRATION & FINANCIAL POLICY

Complete, honest, and legible answers to the questions below are REQUIRED TO RECEIVE CARE IN THIS CLINIC.

Patient Name (First MI Last): _____

Gender: M F **Age:** _____ **Date of Birth:** _____

Height: _____ **Weight:** _____ **Eye Color:** _____ **Hair Color:** _____

Cell Phone: _____ **Home Phone**: _____

Address of where you live (Address on your ID): _____

City: _____**State:** _____**Zip:** _____

Driver's License/State/Federal ID #: _____**State Issued:** _____

E-mail Address: _____

Occupation (If RETIRED, what did you do before you retired): _____ **How Long:** _____

****Person to contact in an emergency**: _____

****Primary Phone #:** _____**What is this person's relationship to you?** _____

***Should we need to contact your emergency contact, may we release information about your condition to this person? Yes No**

Family Physician (Name & Location): _____

Referred By: _____**May we thank the person who referred you? Yes No**

I understand that if I do not show up for my appointment and have not contacted Red Hawk Healthcare at least 30 minutes prior to my appointment, I will be charged a No Show fee of $30.

I understand that I am financially responsible for services or products I receive at Red Hawk Healthcare. **If for any reason, I have an outstanding balance, I agree to make minimum payments of $50.00 each month or 25% of the outstanding balance, whichever is greater. If my account has an unpaid balance for longer than 90 days I will be assessed 5% interest to be compounded monthly until my account is paid in full. If my account is turned over to collections or legal action is required, I agree to pay any and all collection, court and attorney fees in the collection of my outstanding balance. I understand that in addition to attorneys and court cost, a collection fee of 25% of the outstanding balance, including interest, will be added to the final balance.**

I understand that if a check or credit/debit card is returned or declined due to insufficient funds, overages, stop payment, or cancellation of the account, I will be charged a $35.00 service charge in addition to original charges.

I understand that all information provided and all documents, i.e. billing and payment history, treatment files, treatment plans, including conversations or statements made to Dr. D'Amanda, are solely tribal property and are not subject to state, county, city, or professional licensure, laws or rules. Therefore, no information will be provided to anyone without tribal consent.

I understand that refusal to provide the requested information or providing inaccurate information will result in refusal of services. I affirm the information above to be true and accurate to the best of my knowledge. I will not hold Dr. D'Amanda, his staff, or Red Hawk Healthcare responsible for incorrect information or failure to provide information.

Signature of Patient/Guardian: _____**Date:** _____