The Integrative Medicine Center

of Santa Barbara

a higher standard of care

Scott Saunders, MD

NEW PATIENT INFORMATION SHEET

Name: _____Birth Date: _____Gender _____M_____F
Address: _____ Marital Status: ___ Single___ Married___ Other
City/State: _____Zip: _____ SS# __ __ __-__ __-__ __ __ __
Government info; Race (circle one): Refuse / Asian / Black / Black Hispanic / Pacific / White / White Hispanic / Unknown
Ethnicity Hispanic or Latino? (Circle one)__Refuse / Yes / No_____ Language: _____

PLEASE CIRCLE CONTACT NUMBER BELOW FOR APPOINTMENT REMINDERS:

Home Phone #: (____) _____Work Phone #: (____) _____Cell Phone #: (____) _____
Email: _____
Referred By: _____

IF PATIENT IS A MINOR:

Mother's Name: _____Birth Date: _____
SS# __ __ __-__ __-__ __ __ __ Address: _____
Phone #: (____) _____Employer: _____
Employer's Address: _____
Father's Name _____
SS# __ __ __-__ __-__ __ __ __ Address: _____
Phone #: (____) _____Employer: _____
Employer's Address: _____

SUBSCRIBER INFORMATION:

Subscriber's Name: _____Birth Date: _____Sex _____M____F
Relationship to Patient: _____
Address: _____
Employer: _____Work Phone #: (____)_____
Employer's Address: _____

INSURANCE INFORMATION:

Insurance Company: _____
Insurance ID #: _____Account/Group #: _____
Clinician patient is seeing today: _____Effective Date: _____

THIRD PARTY CONSENT:

I authorize integrative Medicine Center to communicate with my insurance company to coordinate treatment to facilitate quality of treatment and obtain reimbursement. By not signing consent, I am agreeing to full payment at the time of service.
Initial: _____

*I understand and agree that, regardless of insurance status, I am responsible for the balance on this account for any professional services rendered. I certify the information provided is true and correct. I will notify Integrative Medicine Center of any changes in the above information, including insurance coverage, in a timely manner. *Initial:* _____

PRINT Patient Name (or parent if patient is a minor): _____

Signature_____Date: _____

5901 Encina Rd #C3
Ph: (805)963-1824 Fx: (805)963-1826
integrativemedicinecenters.com

Patient Name: _____
Patient Date of Birth: _____/_____/_____
(mm/dd)/yyyy)

Integrative Medicine Center of Santa Barbara (IMCSB) Office Policies

 Integrative Medicine Center of Santa Barbara requires 24 business hours (Monday – Friday) notice for appointment cancellations. For example: If the patient's appointment is on Monday at 9:00am IMCSB must receive a call by 9:00am the previous Friday to have given proper 24-business hour notice.
Initial: _____

 There will be a $60.00 charge for any missed appointments, including IV appointments.
Initial: _____

 It is the patient's responsibility to know the date and time of his/her appointment. Appointment reminder calls are a courtesy.
Initial: _____

 The office will verify that we take his/her insurance plan; however, this is not a guarantee of payment. It is the patient's responsibility to know his/her benefits including deductibles, co-pays and visit limitation. In addition, it is the patient's responsibility to keep track of visits used during his/her benefit year.
Initial: _____

 Insurance companies require payment of co-pays/coinsurance at the time of service. Patient co-pays are expected at time of service.
Initial: _____

 IMCSB submits claims only to the insurance companies with whom we are contracted.
Initial: _____

 There will be a $30.00 charge for any returned checks. If there is a history of 2 returned checks, our office will only accept cash or credit card payments.
Initial: _____

 Intravenous drips are not fully covered by insurance. Therefore, it is the patient's responsibility to pay $52 for materials per IV at the time they receive their treatment. If the Insurance Company does not pay then you must pay Cash price.
Initial: _____

 Return Policy for Supplements: Products must be unopened with their seals intact. Unopened products may be eligible for a return credit within 30 days. Returns will be evaluated on a case-by-case basis. Heat sensitive products, perishable and special order items are not eligible for return credit even if unopened.
Initial: _____

As a patient of Integrative Medicine Center of Santa Barbara, I have read and understand the operating procedures, and hereby give permission to the professional staff at the agency to provide diagnostic and/or therapeutic services.

Signature: _____ Date: _____