simple
Wellness • Fitness • MedSpa
phone: 785-856-3030
fax: 866-623-6314
mySimpleHealthcare.com

REGISTRATION

PATIENT INFORMATION:

Name: _____ **Date of Birth:** _____/_____/_____

Gender: Male Female **Primary Language Spoken:** _____ **Marital Status:** Single Married Divorced Separated Widowed

Ethnicity: (Circle One) Hispanic/Latino Non-Hispanic/Non-Latino

Race: (Circle one) African American Alaska Native American Indian Asian Caucasian Hispanic Native-Hawaiian Pacific Islander Other Race _____

Social Security #: _____-____-_____ **Confidential e-mail address:** _____@_____

Home #: _____ **Work #:** _____ **Cell #:** _____

Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Employer: _____ **Work Address:** _____

Primary Care Physician: _____ **Address:** _____

Ok to contact you by mobile texting with results? YES NO

GUARANTOR (if patient is under 18 years old):
Name: _____ **Patient Relationship to Guarantor:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:**_____
Guarantor Date of Birth: ____/____/_____

EMERGENCY CONTACT:
Name: _____ **Patient Relationship to Contact:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Home #: _____ **Work #:** _____ **Cell #:** _____

I understand that all services rendered by the health care providers and/or staff of SIMPLE are considered fee-for-service and must be paid for in full at the time of service. SIMPLE, its physicians and staff, is non-participating with **ALL** insurance companies. I understand I am financially responsible for all charges whether or not they are covered by my insurance. I agree to pay all services at the time of service.

I have been fully informed that SIMPLE aka Samantha Durland, MD is **NOT** a participating provider with my insurance company and I am fully aware that I am utilizing an out-of-network provider and by doing such may cause my insurance benefits to be reduced or in some cases denied completely.

Authorization for Treatment
While I am here, I permit the health care professionals, SIMPLE physicians and staff, to treat me in ways they judge beneficial to me. I understand the attending health care provider will explain to me the nature of my condition and her recommended treatment and any associated risk involved. I also understand that she will explain all possible ways this condition may be treated. I further understand that this care may include diagnostic testing, laboratory testing, examinations and medical and/or surgical treatment. I also understand that no guarantees can or will be made regarding the outcome of this care.

Signature: _____ **Date:**_____