HEALTHY QI & YOU
ACUPUNCTURE & CHINESE MEDICINE
125 W. Richmond Avenue, Suite D
Richmond, CA 94801
510.255.7461
www.healthyqiandyou.com

Patient Registration Form

Patient Information

Patient Information

Last Name:	**First Name:** M.I.:	Previous Name (if applicable)
Mailing Address:	Apt #	
City/State/Zip:		
Home Phone:	**Work Phone:**	**Cell Phone:**
Preferred Method of Contact for Reminders and Other Electronically Generated Messages: (Please Select Only One Option) ☐ Voice ☐ Text ☐ Email (see below)		**If Voice, Please Select Preferred Number:** ☐ Home ☐ Cell ☐ Work
Family Physician or Pediatrician:	**Date of Birth:**	Sex: ❑ Male ❑ Female
Marital Status:	Social Security #:	
Employer Name:	**Emergency Contact Name:**	
Emergency Contact Phone #:	**Relationship to Patient:**	

Additional Information and Responsible Party

Responsible Party - If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor

Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:	Relationship to Patient:	

Additional Information **(PLEASE FILL OUT ALL SECTIONS BELOW)**

Email Address:	**Can we leave a message regarding your medical care?** ☐ Yes ☐ No
Race (please select): ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic or Latino ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Decline	**Ethnicity (please select one):** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline
Preferred Language (please select one): ☐ English ☐ Bosnian ☐ Indian (including Hindi & Tamil) ☐ Sign Language ☐ Spanish ☐ Russian ☐ Other	
Preferred Pharmacy Name & Location:	

Insurance Information

Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Co. Name / Customer Svc Phone #	Ins. Co. Name / Customer Svc Phone #
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy # / Policy Holder's ID #:	Policy # / Policy Holder's ID #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

I certify that I have read and agree to Healthy Qi & You's (HQY) payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to HQY all money to which I am entitled for medical expenses related to the services performed from time to time by HQY, but not to exceed my indebtedness to HQY. I authorize HQY to release any medical information to my insurance carrier or third party payer to facilitate processing of my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $20.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from HQY by text or e-mail at the number or address stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party.

I have completed the above information to the best of my knowledge and state that the information is accurate and true.

ALL INFORMATION PROVIDED IS CONFIDENTIAL AND WILL BE FILED WITH YOUR MEDICAL RECORDS.

Signature of Responsible Party: **X** _____ **Date:**

Printed Name of Responsible Party: **X** _____ **Date:**