ThriveWell Clinic
Dr. Sarah LaIosa D.O.

Date ____/____/____

First Name _____Middle Initial ____ Last Name _____
Date of Birth _____/_____/_____ Social Security Number _____-_____-_____
Gender (circle one):
Male Female Non-binary Prefer to Self-Describe _____ Prefer Not to Say
Relationship Status (circle one):
Married Partnered Single Divorced Separated Widow/Widower
Mailing Address _____ Apartment/Suite_____
City _____ State _____ Zip Code _____
Email_____
Home Phone _____ Cell Phone _____ Work Phone _____
Race _____ Ethnicity _____Primary Language _____
Employment Status (circle one):
Employed Self Employed Unemployed Disabled Retired Student
Occupation _____ Employer _____
Emergency Contact _____ Relation _____
Phone _____

Pharmacy (circle one)

Rite Aid, Hines Safeway, Burns Other_____

Primary Insurance Information

Name of Insurance Company _____ Phone _____
ID/Subscriber Number _____ Group Number _____
Subscriber Name _____ Relationship to Patient _____
Subscriber SSN _____-_____-_____ Subscriber DOB _____/_____/_____

Secondary Insurance Information (if applicable)

Name of Insurance Company _____ Phone _____
ID/Subscriber Number _____ Group Number _____
Subscriber Name _____ Relationship to Patient _____
Subscriber SSN _____-_____-_____ Subscriber DOB _____/_____/_____

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Office and Financial Policies

Welcome to ThriveWell Clinic. We are committed to giving you the best care possible and would like to take this opportunity to inform you of our office financial policies.

Insurance Billing: We are only responsible for filing claims to contracted insurance companies. We file claims as a courtesy to our patients. Any deductibles, co-insurance and non-covered services are your responsibility.

Deductibles and Co-pays: Full payment is due at the time services are rendered; this is a requirement by insurance. This includes co-payments, deductibles, and services not covered by your insurance. If you are on a high deductible plan we collect $150 for new patients and $100 for established patients until the deductible has been met. If you are not able to pay your co-pay or deductible you may be asked to reschedule your appointment.

Late Policy: If you are more than 10 minutes late you will likely be asked to reschedule your appointment.

Returned Checks: There will be a $25 fee assessment for returned checks for non-sufficient funds, stop payments, and account closures. Your account will be flagged for failure to pay and checks will no longer be accepted as a form of payment for your account.

Appointment Cancellation and No Shows: We will attempt to contact you for appointment reminders; however, it is the responsibility of the patient to arrive for his/her appointment on time. We ask that you notify us at least 24 hours in advance to cancel and/or reschedule your appointment.

Prescription Refills: We require office visits on a regular basis for all patients taking prescription medications. Please bring all prescription bottles and a current detailed medication list with you to your appointment. We require at least 2 business days for refill requests to be addressed.

Referrals: All referrals will require an evaluation in the office. If your insurance requires an authorization please keep in mind that it will take 5-7 business days for referral to be completed.

Disability, Family Medical Leave Act (FMLA) Paperwork and Other Forms: An appointment must be made for forms requiring the physician's signature.

Outstanding Balances/Collections: Prior to providing additional services to you, payment in full of total outstanding balances will be required. We will send you 2 statements one month apart and any unpaid balances after 60 days will be assessed a $10 fee per month. You may be sent to collections for unpaid balances after 60 days.

Acknowledgement: I acknowledge that I have received and read a copy of the Office and Financial Policies.

_____ Patient/Guarantor Name (please print)

_____ Signature of Patient/Guarantor