460 Ashley Ridge Blvd, Ste 600, Shreveport, LA 71106 318.861.4226

PATIENT REGISTRATION

Last name: _____ First name: _____ MI: ____ ☐Male ☐Female

DOB_____ ☐Asian ☐African American ☐Am Indian ☐Caucasian ☐Hispanic ☐Other

SSN: _____ ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Home address: _____ City: _____ State: ____ ZIP: _____

☐Employed ☐Not Employed ☐Retired ☐Student Employer:_____

Phone 1: _____ ☐Home☐Work ☐Cell Phone 2: _____ ☐Home ☐Work ☐Cell

Email Address: _____

Billing address: ——☐Same as home. _____

City: _____ State: _____ ZIP: _____

I authorize use of email to send me information regarding my medical care: ☐Yes ☐No
I authorize cellular calls and texting for appointment reminders, billing and medical care: ☐Yes ☐No
Preferred Method of Contact: ☐ Text Message ☐ Email ☐ Phone ☐ No Preference

Emergency contact: _____ Phone: _____ Relationship: _____

Family Physician:_____ Phone:_____

How did you hear about White Clover?_____

INSURANCE INFORMATION: (If Applicable)

Primary Insurance :_____ Patient Relation to Member: ☐Self ☐Spouse Child ☐Other

Member Name:_____ DOB_____ SSN_____

Policy #_____ Group#:_____

Secondary Insurance:_____ Patient Relation to Member: ☐Self ☐Spouse Child ☐Other

Member Name:_____ DOB_____ SSN_____

Policy #_____ Group#:_____

PATIENT REG (Page 2) Last Name_____ First Name_____

TERMS:
I understand that I am responsible for any charges incurred for services provided by White Clover Wellness & Research Center ("White Clover") and its staff/associates/business associates.

White Clover requires 24 business hours (Monday-Friday) notice for appointment cancellations. Otherwise, a cancellation fee will be charged up to the full fee of the appointment.

Office hours are Monday thru Friday 8am – 5pm. The staff is not on-call after business hours. In the event of an emergency, go to the nearest Emergency Room

There will be a $35 charge for any returned checks.

White Clover reserves the right to refuse treatment if we feel it is in the best interest of the client.

Please leave all jewelry and other valuables at home. We are not responsible for lost valuables.

We love children, however, we are not able to accommodate children during your visit.

Gift Certificates are treated as cash and not redeemable if lost or stolen. No refunds will be given for gift certificates.

To receive package-priced discounts, the entire package must be purchased in advance. Packages cannot be shared between customers.

Prices and services are subject to change without notice.

RIGHTS & RESPONSIBILITIES:
I understand that I have the right to receive accurate and easily understandable information about White Clover services. I further understand that I have the right to considerate, respectful care from the staff. I also understand that I am responsible for communicating clearly and respectfully with the White Clover staff. Should I become dissatisfied with my care or the White Clover services, I agree to notify White Clover Wellness immediately so my concerns may be addressed in a timely manner.

In order to receive the best possible care, I agree to be actively involved in my health care decisions and to disclose all relevant information to White Clovers staff so that they can help me achieve my health goals. I also agree to inform White Clover of all outside health care services I receive for any reason (such as emergency room, specialist, or hospital services).

By my signature below, I INDICATE THAT I HAVE COMPLETELY READ, FULLY UNDERSTOOD, AND HAD THE OPPORTUNITY TO DISCUSS WITH WHITE CLOVER STAFF ALL THE TERMS, RIGHTS AND RESPONSIBILITIES CONTAINED IN THIS PATIENT AGREEMENT AND DISCLOSURE STATEMENT. I also agree to become a patient of White Clover Wellness & Research Center.

I authorize White Clover to file my insurance for services rendered and request that payment of benefits be made to White Clover. I authorize any holder of medical information, including White Clover, to release to my health insurance carrier or any other third party payor any information needed to determine benefits payable for related services and direct the insurance company to release such information to White Clover Wellness & Research Center.

I authorize White Clover Wellness & Research Center and their staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment. **Right to Refuse Treatment**: In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

Signature:_____ Date: _____

Print name:_____ Signature by: □Patient □Parent □Legal Guardian

Basis of representative's authority to act for patient:_____