

Flourish Women's Wellness
Alisha Madrone, NP, CNM

Name _____ Birth Date _____ SS# _____ Date _____

Address _____ City _____ State _____ Zip _____

Phone _____ E-mail _____ Preferred Contact _____ Phone _____ E-mail _____

Occupation _____ Employer _____

Marital Status _____ Partner's Name _____ Phone _____

INSURANCE INFORMATION

Insurance Company _____ Phone _____

Insurance Claims Address/Payer ID _____

Policy/ID # _____ Group/Plan # _____

Subscriber Name _____ Subscriber DOB _____ SS# _____

EMERGENCY CONTACT

Emergency Contact (Name, relationship, phone) _____

REFERRAL

Whom can I thank for referring you to Flourish Women's Wellness? _____

Flourish Women's Wellness
Alisha Madrone, NP, CNM

AGREEMENTS

1. Consent to Treat: I understand that Alisha Madrone, NP, CNM has an advanced practice degree and offers her skills and knowledge in health promotion and education as well as evaluation, diagnosis, and treatment or coordination of care for teenage and adult women. By signing below, I am requesting that Alisha Madrone, NP, CNM examine and treat me.

2. Financial Responsibility: I acknowledge that I am financially responsible for all charges incurred regardless of insurance coverage.

3. Cancellation/No Show Policy: By signing below I acknowledge that less than 24 hour cancellation notice will result in a \$25 charge and that not showing for an appointment without rescheduling that day will result in a \$45 charge.

4. Acknowledgement of Privacy Policy: I acknowledge that Alisha Madrone, NP, CNM respects the privacy of my medical records and will do the best she can to secure and protect that privacy. In some circumstances, Alisha Madrone, NP, CNM may be asked to disclose health information about me for purposes of insurance payment or, if requested in writing, for another practitioner. I reserve the right to revoke this consent by submitting my preferences in writing at any time and understand that I can speak with either Alisha or a HIPAA compliance officer for further clarification of privacy policies set forth by the Department of Health and Human Services.

5. Authorization to Communicate via E-mail: Communication via e-mail can be convenient for all parties; however, e-mails may not be encrypted and could be read by some outside party with the skills to access this information.

By initialing here_____, you consent Alisha Madrone, NP, CNM to communicate via e-mail in spite of the above.

Printed Name_____

Signature_____

Date:_____