ELIXIA
wellness group

CONFIDENTIAL PERSONAL INFORMATION

Full Legal Name: _____/_____/_____
(Last Name) (First Name) (Middle Initial)

Preferred Name: _____ Age: ____ Date of Birth: _____ Gender: F_____ M_____

Address:_____/_____/_____/_____
(street#/PO Box) (city) (state) (Zip code)

Telephone # _(____)_____/_(____)_____/_(____)_____
(cell phone) (work) (home or other)

Are you (check one): Single ____ Married ____ Other ____ Partner's Name: _____

Occupation: _____ Emergency Contact: _____ Ph#: _____

Patient E-mail*: _____

How did you hear about our clinic? Internet | Walk or Drive By | Doctor/Practitioner | Friend

If you were referred by a friend or practitioner, whom may we thank? _____

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*Email Policy and Preferences

Check the appropriate boxes below to indicate your preferences. Please be aware that e-mail addresses listed on our website and business cards are for general inquires only and are not a secured means for relaying personal health information**.** *Emails are NOT sold or distributed. Marketing is specific to Elixia news, events and practitioners.*

☐ **Appointment Reminders:** Yes, I would like email reminders about upcoming appointments. (Reminders are sent 1 week and 1 day prior to appointments.)

☐ **Yes, I want access my patient portal and enable secure email messaging**. (Includes everything shared by your doctor, such as medications, diagnoses, immunizations, and lab results). You will be emailed a link to a secure, HIPPAA-compliant site. * *Please note, not all practitioners choose to use email as a way to communicate with their patients. Please discuss individually with your practitioner**.***

☐ **Yes I would like to receive e-newsletters** and occasional notification of marketing events from Elixia.

*****Missed Appointments****:** For appointments missed or cancelled with less than 24 *business* hours' notice, a fee *starting at $35 up to the maximum return office visit rate,* will be charged. Check with your individual provider or the front desk, so you are aware of which cancellation fee applies to your visit. **Initial** _____

Credit Card Authorization: Some cases require us to obtain your credit card: Repeat missed appointments, shipping supplements, or any other balance you may have. Your consent is needed for it to be kept on file and charged in accordance with our policies, you are authorizing the charge. We will charge no more than $100 to the patient's credit/debit card without notice. **Initial** _____

Informed Consent (end of packet): I have read and initialed that I am aware of the risks and benefits of services and therapies provided by Elixia Wellness Group. I agree to these services, except those declined as circled. **Initial** _____

Notice of Privacy Practices: I have read and agreed to the Elixia Wellness Group Privacy Practices revision #2014 at the end of this packet. I have been offered a copy of these policies, and if accepted, received a copy. **Initial** _____

By signing below, I verify that the above information is correct and true to the best of my knowledge.

Signature of Patient: _____ **Today's Date:** _____

Revised 7/1/14

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