NEW PATIENT CHECKLIST

PLEASE INITIAL EACH ONE ONCE COMPLETED

____ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

____OFFICAL CONSENT OR MINOR AUTHORIZATION OR MEMBERSHIP AGREEMENT

____ENROLLMENT FORM WITH DEMOGRAPHICS AND LIST OF MEDICATIONS

____TELEHEALTH COMMUNICATION CONSENT (IF OUT OF STATE)

____RECIEVED COPY OF HIPPA PRACTICES

____COPY OF DRIVERS LICENSE

____COPY OF INSURANCE CARD IF APPLICABLE

___PAYMENT METHOD

REPRESENTATIVE SIGNATURE_____

RELATIONSHIP TO PATIENT_____

DATE: _____

OFFICE USE ONLY:

REVIEWED AND DOCUMENTED BY: _____INITIALS