AUTHENTIC HEALTH
NUTRITION · CHIROPRACTIC · COLD LASER

New Patient Application

AuthenticHealthLLC.com

Full Legal Name:

Name you'd like to be called: Date:

DOB: Gender: F M Gender at Birth: F M

Address: City: State: Zip:

Maritial Status: S M D W # of Children: SSN:

Cell: Home: Work:

Email: Referred By:

Employer: Occupation:

Emergency Contact: Phone: Relation:

If we're unable to reach you, would you like us to: Leave detailed message Message to return call

Would you like to sign up for our email newsletter?: Y N (You may opt-out at any time)

APPOINTMENTS

Any appointments not canceled by calling, texting, or emailing (Dr.JillBalla@gmail.com) the office 24 hours prior may be subject to a cancelation fee of $25 for adjustment evaluation appointment, $85 for Chiropractic or Nutrition Exams, $135 for 90 min/$90 for 60 min/ $45 for 30 min therapy appointments. This charge is the responsibility of the patient and cannot be billed to the insurance company.

PAYMENT

Payment is expected in full at the time of services and purchases and can be paid via cash or credit card. Any payment arrangements for services must have been made in writing in advance of the day of your visit. Personal checks will be accepted at the discretion of Dr. Balla for established patients. Any returned checks will be assessed a $30 returned check fee and the office will no longer accept personal checks for the account or related accounts. Outstanding balances over 30 days will be charged a monthly interest rate of 5%. Accounts overdue by 120 days will incur a 30% processing fee and sent to litigation. The patient or patient's guardian is responsible for outstanding balances, court costs and attorney's fees. We do not accept health insurance but will provide a Superbill upon request.

RETURNS

Unopened, unaltered products in the original undamaged boxes may be returned within 45 days of purchase. Homeopathics and refrigerated probiotics cannot be returned.

Any previous agreement is hereby superseded, replaced in its entirety and considered null and void.

I HAVE READ, UNDERSTOOD AND AGREE TO COMPLY WITH THE TERMS SET FORTH HEREIN.

Patient Name (print) Patient Signature Date

Parent/Guardian Name (print) Parent/Guardian Signature Date