



ISHSKO Wellness Centre Ltd

NEW PATIENT REGISTRATION FORM

(First, Middle, Last Name) (Date of Birth)

(Address) (Town, County, Postcode)

(Home Telephone Number)

(Work Telephone Number)

(PPS Number)

(Mobile Phone Number)

(Email Address – Please Print Clearly)

The ISHSKO CENTRE regularly send out up dates on the lasted developments within the field of Integrative medicine.
Please tick the box if you do not wish to receive ISHSKO CENTRE related updates and information via email

Please tick the box if you would like to subscribe to our newsletter

Marital Status: Single / Married / Divorced / Widowed
Gender: Male / Female
Employment Status: Employed / Part-time / Student / Full-time Student / Other

Employment Information

(Occupation) (Employer)

(Town) (County, Post code)

Responsible Person (If Applicable)

(Name or Names) (Date of Birth) (Relationship to Patient)

(Address) Town) (County, Post code))

(Phone Number) (PPS number (for MED 2 purpose)) (Occupation)

(Employer) (Employer Phone Number)

Relative to Contact in Case of Emergency (Not Living in Home of Patient)

(Name) (Phone Number) (Relationship to Patient)

(Address) Town) (County, Post code)

How were you referred to our Centre?

Please print the name of your source below.

By a Doctor _____

By a practitioner _____

By a Patient _____

Other _____

Consent to Treatment

The ISHSKO WELLNESS CENTRE Ltd offers Integrative biological dentistry, Autonomic Response Testing, Nutritional therapy, Manual therapies and detox suite therapies.

Please tick the following:

- I voluntarily consent to receive combined Dental and Complementary Health care services that may include diagnostic procedures, examinations and treatment.**
- I do not consent to receive combined Dental and Complementary Health care services that may include diagnostic procedures, examinations and treatment.**
- I request to receive dental treatment only**
- I request to receive Complementary therapies only**

I understand that my GP is ultimately responsible to dealing for my general health issues. I understand that communication between the Centre and my GP may be necessary and communication will be conducted according to the centre's patient confidentiality guidelines. (see Patient Confidentiality form PC207)

Financial Responsibility

I understand that the consultations and therapy fees as well as the costs for laboratory test are available from our reception or downloadable from our website www.ishskowellnesscentre.com. Dental treatment estimates and/or costs for our personalised wellness programs are discussed prior your next visit, to bring clarity to the cost of your dental and/or wellness program. I understand that Treatment options are varied and I need to consent to the final decisions on the type of treatment I will commit to at the Centre. Finance Plans are available for treatment and program costs over 1000 Euros and need to be approved and be set-up before treatment commences. Please ask our practice manager for details. If no treatment payment plan is asked for by the patient, it is assumed that payment is made on the day it is rendered. Where extensive dental treatment is necessary, 50% of the full treatment plan costs will be due prior to the dental treatment commences.

I agree to pay all charges for dental and/or health care services at the ISHSKO Wellness Centre, either as the services are rendered, or by Standing Order by prior approval.

I understand that the practitioners here at the ISHSKO WELLNESS CENTRE are **not** "in-network providers" with any insurance companies and that the Centre operates as a "fee-for- service" Centre and that all services must be paid for at the time of the visit, unless a prior arranged Finance contract is approved.

I understand that I will be paying for Health advice by "contact" with the Dentist, Nutritionist, A.R.T. therapist whether by email, phone or in-person; irrespective of whether my insurance offers reimbursement for this type of contact. Charges for "non-local" contact will be at the discretion of the practitioner and will be charged at prevailing rates; however, in most cases this will not apply for urgent phone contact that lasts less than ten minutes). I agree to allow the ISHSKO Wellness Centre to charge my credit card for any outstanding balances that may occur from time to time with *prior* knowledge to me. The Centre does not store credit card details.

I understand that if I choose to enroll into the ISHSKO WELLNESS CENTRE - COACHING program, that fees for non-local contact with our practitioners will be included in the cost of the wellness coaching program fee and this contact is pre scheduled with the appropriate practitioner in advance. MISSED appointments, will be charged if no 48 hour prior notice is given.

I also understand that due to the often long appointments and combination of therapies with several practitioners within the Centre, the office has a **48-hour cancellation policy** and that it is **strictly enforced** and does not include weekends or holidays (i.e. an appointment that is scheduled for Monday morning at 10 am must be cancelled by 10 am on Friday morning in order to avoid a cancellation charge). Cancellation fees will be based upon the amount of time that is scheduled for the office visit. The Centre will attempt to contact you by text message, as a courtesy **3 days** prior to your scheduled appointment time as a reminder by prior arrangement.

I understand it is my responsibility that contact details are up to date and It is important to inform us of any changes of address/ email or mobile phone numbers.

The ISHSKO Wellness Centre complies with privacy rules and I have read the copy available at the reception and agree to the policies that this office operates under.

I certify that I have read this form and understand its contents.

(Patient or Other Legally Authorized Person)

____/____/20____
(Date)