

BHRT & Integrative Wellness LLC
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Phone (907)622-2478
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CLIENT INFORMATION

Today's Date: _____

Client Name: _____ DOB: _____

Mailing Address: _____
Street City State Zip

Home Phone: _____ Work Phone: _____

Parent/Legal Guardian (if different from client): _____
(Person responsible for bill if patient is under 18)

Emergency Contact: _____ Phone: _____

Relationship to Emergency Contact: _____ Referral Source: _____

Responsible Party Employer: _____

Method of Payment Today: ☐ Cash/Check ☐ Credit Card ☐ Money Order

***CANCELLATION POLICY: There is a fee charged for appointments not cancelled 24 hours prior to the scheduled appointment which is 100% of the scheduled visit charge.**

CLIENT PAYMENT AGREEMENT

I understand that I am responsible for all charges accrued at any visit.

THIS FACILITY IS NOT ENROLLED IN FEDERAL OR STATE PROGRAMS, AND THEREFORE DOES NOT ACCEPT ASSIGNMENT OF BENEFITS FOR FINANCIAL PROGRAMS OF THIS NATURE.

SIGNATURE: _____ DATE: _____

WITNESS: : _____ DATE: _____