Mulberry Clinics

REGISTRATION

PATIENT INFORMATION

First Name:	Last Name:	MI:	DOB:	▫ Male ▫ Female
Home address:	City:		State:	Zip:
Billing address: ▫ Same as home	City		State:	Zip:
Phone #1: ( )	▫ Home ▫ Work ▫ Cell Phone	#2: ( )	▫ Home ▫ Work ▫ Cell	
Email address:				
Emergency Contact:	Phone: ( )		Relationship:	

FUNCTIONAL CONSULT RATES (subject to change)

CHOOSE ONE: ▫ 1 Visit Plan - $485/hour (1 visit) ▫ 3 Visit Plan - $1,200/3 hours (3 visits)

BILLING

Credit or debit card #:		Expiration:	3 Digit Security #:
Card Billing Address: ▫ *Same as home*	City:	State:	ZIP:
▫ *Please add me to the billing account of an existing Mulberry Clinics patient associated with the above credit card*			
Email Address:			

PRIMARY CARE PROVIDER

▫ I understand that as a functional consultation patient only, I am required to have a Primary Care Provider on file at all times			
Primary Care Provider Name:			
Address:	City:	State:	ZIP:
Phone #: ( )	***(Circle one)*** I | DO | DO NOT| give permission Dr. Hutton to communicate with my Primary Care Provider		

AUTHORIZATION

I understand and agree to the following (read and initial all items indicating your acceptance):

____ I may cancel at any time, but no refunds will be issued for the paid fees.

____ I will pay a $25 fee for declined credit or debit card transactions and a $50 fee for returned checks.

____ My participation is voluntary and subject to the terms detailed at mulberryclinics.com.

____ I understand that **this agreement does not include comprehensive health insurance coverage nor is a contract of insurance**.

____ I understand specialty care, hospitalizations, surgery, third-party medical treatments, and other medical products and services not specifically provided by Mulberry Clinics are my sole responsibility and are not included or paid for by Mulberry Clinics.

____ A $100 deposit is required at the time of booking a function consultation appointment. This will only be refunded if the appointment is cancelled within 48 hours prior to the appointment time.

____ 3 visit plan will be prepaid at time of first appointment.

____ Any unused appointments are non-refundable.

SIGNATURE: _____ DATE: _____

PRINT NAME: _____ SIGNATURE BY: ▫ PATIENT ▫ PARENT ▫ LEGAL GUARDIAN

Mail/drop off completed form to: Mulberry Clinics · 5328 Main Street, Suite K, Spring Hill, TN, 37174

615.614.2500