Mulberry Clinic
Spring Hill

ROOT CAUSE PROTOCOL REGISTRATION

PATIENT INFORMATION

First Name:	Last Name:		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:

ROOT CAUSE CONSULTATION RATES

CHOOSE ONE: ▢ 1 Visit Plan- $380 ▢ 3 Visit Plan - $900/3 visits

BILLING

Credit or debit card #:	Expiration:	3 Digit Security #:	
Card Billing Address:	Citv:	State:	ZIP:
☐ Please add me to the billing account of an existing Mulberry Clinics patient associated with the above eveclit card			
Email Address:			

PRIMARY CARE PROVIDER

▢ I understand that as a Root Cause 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 Beth Norwood permission 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 and conditions of membership detailed at MulberryClinicSpringHill.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 Root Cause 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: _____

PRINTNAME: _____ 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