Rain Shadow Integrative Medicine

Practice Registration Form

Name: _____ _____ _____
(First) (Middle) (Last)

Address: _____ _____ _____ _____
(Street Address) (City) (State) (Zip Code)

Email Address: _____ Date of Birth _____

Phone Numbers:

(Home) _____ (Mobile)_____

(Other) _____

What is your preferred method of communication? _____

Local Emergency Contact: _____ _____ _____
(Name) (Relationship) (Phone Number)

Who may we share your care information with?

Name	Relationship	Phone Number

Authorization for Credit Card On File Payment

NOTE: Your credit card information is not kept on file in this office. It is kept securely offsite and this office does not have access to the full credit card number once it is entered into the system the first time.

AUTHORIZATION

Until further notice, I authorize Rain Shadow to charge fees for services rendered to the following credit card:

Circle one: Visa Mastercard Discover A/E

Last 4 digits of my credit card: _____ Exp. Date (mm/yy):_____

Signature:_____ Date: _____