

ATHENS NATURAL MEDICINE

Naturopathic Medicine and Acupuncture

Consent Form Confidential

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Please print registration information. Thank you.

.....

Today’s Date: _____

First Name _____ M.I _____ Last Name _____

Phone#: Home _____ Work: _____ Cell: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email Address _____

Sex: _____ Age _____ Birth Date: _____ Single/Partnered/Married/Other(Circle)

Occupation: _____ Employer’s Name: _____

Who is financially responsible for this account? _____

Spouce/Partner’s name: _____ phone #: _____

Emergency Contact Name: _____ phone#: _____

My General Practitioner is: _____

My OBGYN is: _____

I understand that although Naturopathic Physicians are licensed health care providers in many states, they are not currently licensed in the state of Georgia and that any naturopathic therapies or modalities recommended by Dr. Allen are not meant to replace conventional treatments prescribed by my M.D.

I understand that Naturopathic physicians are not covered by insurance companies in Georgia and that all payments are due at the time of services rendered.

I understand that if I do not cancel an appointment with **48** hours notice, my credit card on file will be charged \$65 for follow ups or \$100 for a new patient appointment.

Patient or Guardian’s signature _____

In the space below please tell me how you found out about my practice and if you were referred by someone. Thank you!