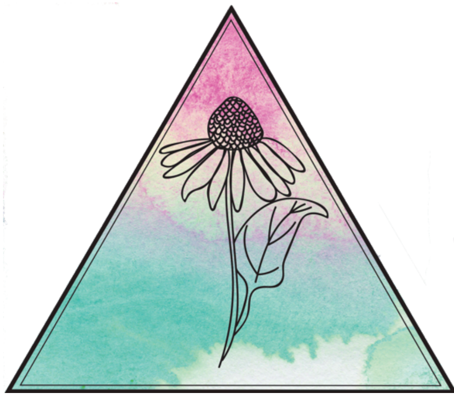

ENDOCRINE WELLNESS

Dr. Annette Kutz Schippel
1035 Junction Circle – Springfield, IL 62704
Phone (217) 370-5060 Fax (217) 210-0452

Email: endocrinewellness@gmail.com
www.endocrinewellnessgroup.com

Patient Information

Date: _______________

Full Name: ________________________________ DOB: _____/_____/_____

Address: __________________________________ Preferred Phone: _____________________________

City, State, Zip: ____ Atl. Phone: ______________________

Email: _____________________________ Skype: __________________ Fax: _____________________

Sex: M   F   Age: _______   Marital Status: ___ Single ___ Married ___ Widowed ____ Divorced

Occupation: _________________________ Height: _____________ Weight: ______________

Who is your primary care physician? ____

Are you seeing any other healthcare provider? ____

Who may we thank for referring you? ____

Billing Information: You must provide a credit/debit card number below or provide one over the phone when your consult is scheduled.

Credit Card Type: Visa / MasterCard / Discover/Amex (please circle one)

CC #: ________ ________ ________ ________ Expiration Date: ________ / _________

CVV: ___________________   Zip: _________________

CONSENT TO TREAT

I hereby authorize this office and its doctors to examine and administer care as the examining/treating doctor deems necessary. I understand and agree that I am personally responsible for payment of all these fees charged by this office for such care.

HIPAA – NOTICE OF PRIVACY POLICIES

The notice of privacy practices describes how we may use and disclose your protected health information to carry out treatment, payment or other healthcare operations. It also describes your rights to access and control your protected health information. "Protected health information" (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health. Please be advised that our office may deem it necessary to discuss your PHI with other treatment facilities, laboratories, or payment centers, among other reasons, with or without your consent. A full explanation of our rights and responsibilities as a healthcare facility and your rights as a patient, under HIPAA requirements, is available upon request.

DISCLAIMER

Please be advised that the nutritional and herbal programs that are administered by our office, and/or Dr. Annette Schippel are not intended as a primary therapy for any disease, but rather to provide nutritional and herbal support for normal body physiology and repair. Also be advised that any and all testing ordered by our office and/or Dr. Annette Kutz Schippel, whether it be by saliva, hair analysis and/or blood work is not used to treat or diagnose any disease. These types of testing simply offer guidance on how to use whole food supplements and herbs to support and balance the body, while dealing with imbalances.

BILLING

We do not bill insurance for nutritional services, nor do we provide CPT or diagnosis codes for you to do so, as the nutritional work performed by Dr. Annette Kutz Schippel is not designed to diagnose or treat a disease. We would appreciate it if you were prepared to pay your consultation fee at the time of service.

RETURN POLICY

Supplements must be in their original box/package. Boxes and bottles must be unopened. No expired products will be accepted. Any returns, for any reason are subject to a 20% restocking fee. No exceptions.

Please sign to confirm that you have read and understand the above information.

Patient Signature ______________________________ Date ___________________________

Thank you so much for taking the time to fill out this packet of information.
We look so forward to working with and getting to know you. We are dedicated to finding the best individual path for each of our patients.