THERMAL MED RX., Inc.
Your Prescription For Life
601 Jefferson Davis Highway, Suite 201
Fredericksburg, Virginia 22401
540-368-5558
www.ThermalMedRx.com

PATIENT REGISTRATION

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Address: _____

_____

Home Phone: ( ) _____ **Cell Phone:** ( ) _____

Social Security #: _____ **Birth date:** _____

Email Address:_____

Martial Status:_____ **Spouse's Name:** _____

☐ **HIPAA**: I have read and understand my privacy rights under the HIPAA Policy.

☐ **PAYMENT POLICY**: Dr. Schulz is a non-participating provider (including Medicare and Medicaid); therefore, full payment is expected at the time of service by cash, check or credit card. Documentation will be provided to you for reimbursement from your insurance. I understand Dr. Schulz is not my primary provider. Any unpaid balances are due within 30 days of treatment. Should your account be forwarded to a collection agency, you will be responsible for an additional 50% fee of the collected amount.

☐ **CONSENT FOR MEDICAL RELEASE**: I hereby request a copy of my thermogram and report to be sent to my doctor listed below. An additional copy will be sent to your doctor for your records and will receive from your doctor at the time of your consultation regarding your thermogram results.

Doctor Name: _____ **Phone:** _____

Address: _____

City: _____ **State:** _____ **Zipcode:** _____

_____ _____

Signature of Patient or Responsible Party ***Date***