We appreciate your time in completing all highlighted sections on this page:

Patient Name:_____ Date of Birth: _____

TREATMENT AUTHORIZATION: I authorize medical treatment of myself or my minor child by Dr. Sica & staff. **I understand that Dr. Sica does NOT provide primary care services and it is my responsibility to maintain a primary care physician.**

My primary care physician is:

Name: _____ Address: _____

Phone: _____ City State Zip Code: _____

I am also being treated for _____

BY: Physician Name: _____ Address: _____

Phone: _____ City State Zip Code: _____

Patient Request for Email Communication:

Please complete the information below if you wish to communicate with Dr Sica or her staff via email, knowing there are inherent privacy risks. This document, along with any and all email communications, may become part of your medical record.

Email Address: _____

Please initial each line and sign below:

_____ *My email address above is accurate and I accept full responsibility for messages sent to or from this address.*

_____ *I hereby authorize the Dr Sica and the Center for the Healing Arts to send me health information and newsletters by email.*

_____ *I have read, reviewed, and received a copy of this HIPAA Notification: Electronic Mail Communications.*

_____ *I understand and acknowledge that there are inherent privacy risks when communication is over the Internet.*

_____ *I agree to hold The Center for the Healing Arts, PC, and its agents and representatives harmless from any and all claims and liabilities arising from or related to this Request for Email Communication.*

PATIENT ACKNOWLEDGMENT: I certify that the information I provide to my practitioners and my insurance company is correct. I certify that I am here to receive medical care and for no other purpose. I do not represent any third party.

_____ *By signing and dating this form, I acknowledge that I have READ copy of Dr Robban Sica's Notice of Privacy Practices.*

_____ ***By signing and dating this form, I acknowledge that I have read Dr Robban Sica's AUTHORIZATIONS & ACKNOWLEDGEMENTS, INCLUDING FEE & PAYMENT INFORMATION AND CANCELLATION POLICY OF 48 HOURS.***

I attest, to the best of my knowledge, the above information is accurate and true.

Signature: _____ *Date:* _____

If executed by a patient's legal guardian, please complete the following information: *(Please print)*

Legal Guardian's Name _____ *Relationship:* _____

Patient Registration: Check whether this is your:

☐ INITIAL CONSULTATION: Complete all information below and FAX, Email, or bring to appt.

☐ ANNUAL UPDATE: Check here if there is NO CHANGE _____

*****Update any changes below, including credit card information**

Whom should we thank for referring you?			Date
Full Name	DOB	Age	☐ Male ☐ Female
Address			
City	State		Zip Code
Home Telephone	Work Telephone		Mobile
Social Security Number	Email Address		
Emergency Contact Name	Relationship		Emergency Contact Number

Insurance Information

Primary Insurance Carrier	Group Number	ID Number
Primary Insured	Employer Name	
Business Address		
Employee Social Security Number	Employee Date of Birth	

Financial Responsibility

Person Responsible for Account: ☐ Self ☐ Spouse ☐ Parent ☐ Other	
Name (if other than self)	Email Address
Address Telephone	

Credit Card Payment Authorization: Alternative payment may be made by check or cash at the time of service.

I _____, hereby authorize Dr Sica / Center for the Healing Arts, PC to charge my credit card for services rendered and/or products supplied for a period of one year from the date below. It is my responsibility to notify Dr Sica / Center for the Healing Arts, PC of any changes regarding this credit card authorization.

Name on Card	Signature/Date	
Credit Card Type ☐ MasterCard ☐ Visa ☐ Discover	Credit Card Number	
Expiration Date	Security Code	Billing Zip Code