Your Hospital's Logo Here

REGISTRATION FORM

Wellness Institute Clinical Services

NAME:		
ADDRESS:		
CITY:	STATE:	ZIP CODE:
DAYTIME PHONE:	EVENING PHONE:	
HOW DID YOU HEAR OF THE WELLNESS INSTITUTE ?		

SERVICES	DISCOUNTED FEES	SERVICES	DISCOUNTED FEES
☐ Men's Assessment	$ 125.00	☐ HELP Program	$ 125.00
☐ PSA Blood Test	$ 65.00	☐ Nutrition Visit	$ 45.00
☐ Women's Assessment	$ 125.00	☐ Hypertension Management	$ 75.00
☐ School / Emp. Exam (exam only)	$ 50.00	☐ Smoking Program	$ 75.00
☐ Cholesterol Profile	$ 35.00	☐ Breast Exam Program	FREE
☐ PPD Skin Test	$ 35.00	☐ Project WISH	N / A
☐ Other		☐ Other	

IMMUNIZATIONS	DISCOUNTED FEES	IMMUNIZATIONS	DISCOUNTED FEES
☐ Tetanus	$ 21.00	☐ Lyme Disease Vaccine	$ 150.00
☐ M M R	$ 65.00	☐ Varicella Vaccine Series	$ 130.00
☐ Hepatitis B Vaccine Series	$ 175.00	☐ Pneumonia Vaccine	$ 65.00
☐ Hepatitis A Vaccine Series	$ 130.00	☐ Flu Vaccine	$ 15.00
☐ Other		☐ Other	

TOTAL PAID: _____

PAYMENT: ☐ CASH ☐ CHECK ☐ VISA ☐ MC ☐ AMEX ☐ INSURANCE
☐ OTHER _____

I understand that if I am using my insurance, the carrier will be billed the Standard Hospital Charge for the services received. I understand the Standard Hospital Charge is greater than the Wellness Institute Cash Discounted Price. I also understand I will be responsible for any charges of clinical services not covered by my insurance carrier not to exceed the Cash Discounted Price.

SIGNATURE:	DATE:
STAFF:	

PART OF THE MEDICAL RECORD