**New Patient Information** (Please print clearly)

**Contact Information:**

Patient Name:_____ DOB_____

Mailing Address:_____ Zip:_____

Home Phone:_____ Check if OK to leave detailed message: ___YES

Cell Phone:_____ Check if OK to leave detailed message: ___ YES

Work Phone:_____ Check if OK to leave detailed message: ___ YES

Email Address:_____ Check if OK to leave detailed message: ___YES

**Practitioner Information:**

Name:_____

Address:_____

Phone:_____

Fax:_____

Email Address:_____

Referred by your practitioner? Yes____ No_____

## ❖ Please Read and Sign ❖

- I understand that payment is requested at time of service.
- Fee Schedule:
    - $150 for New Patient Consultation.
    - $60 for follow-up either by phone or through appointment. Follow-up usually results in informing your medical practitioner with a progress report and often a request for a change in your prescription.
- **Authorization to Release Medical Information**: I hereby authorize Good Day Pharmacy and any licensing organizations to review and obtain copies of my medical record (e.g., medical history, prescription formulas, patient notes, patient lab tests, etc.) and insurance information, as they relate to my therapy, to my reimbursement to Good Day Pharmacy, and for care coordination, quality assurance, accreditation, or licensing reviews. I also hereby authorize Good Day Pharmacy to furnish to my insurance carriers and other health care providers, any medical history, lab testing, proof of services rendered, or plan of care recommended.

I understand that these authorizations take effect immediately and that a fax or photocopy is as valid as the original.

I have read and understand all the information stated above.

SIGNED_____ Date:_____

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