Redbud Health Services
500 E 3RD ST
Buchanan, MI 49107-1404

Phone: (269) 409-8626
Fax: (269) 273-8457

Intake Form

Last Name:		First Name:	
Address:		Apt or PO Box:	
City:			
Zip:			
Contact Information:			
Home Phone:		Email:	
Cell Phone:		**Sign up for Apt Reminders?**	**[ ] TEXT [ ] EMAIL**

Emergency Contact

Last Name:	First Name:
Phone:	
Relationship:	

Primary Care:

Primary Physician:

May we send updates to them? [ ] Yes [ ] No

Motor Vehicle Accident Injuries

If you are receiving care for injuries from a Motor Vehicle Accident, what state did the accident occur in? _____

Insurance / Pay As You Go- Please select one of the following:

All insurances will be billed at the current insurance rate. Patient will still be responsible for co-pays and meeting deductibles.
[ ] I understand the above statement and prefer you to bill my insurance company for all treatment that I receive.

Pay As You Go Rate will be billed to the individual patient at a rate of $250.00 for an initial evaluation appointment and $150 for a standard visit. Insurance will not be billed.
[ ] I understand the above statement and prefer the Pay As You Go rate option and am aware that I will be responsible for all payments and my insurance will not be billed. Upon request I will be provided information regarding treatment and diagnostic codes. I may use this information should I choose to submit it for insurance reimbursement.

[ ] I acknowledge that If I am unable to keep my appointment time to call 24 hrs. in advance to cancel or a $40.00 cancel fee will added on to account, Insurance will not cover this fee.

Patient Signature:_____ Date:_____