Fal River Health Center
202 U.S. Route One, Suite #203 • Falmouth, Maine 04105
Phone: (207) 781-7880 • Fax: (207) 781-7882
www.falriverhealthcenter.com

Date: _____

PATIENT
First Name: _____ Middle Initial: _____ Last Name: _____

D.O.B: _____ Gender: _____ Social Security Number: _____

Phone: (c) _____ (w) _____ (h) _____

Address: _____ City: _____ State: ____ Zip: _____

Email: _____

Primary Care Physician: _____ Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

Who referred you: _____

Emergency contact: Name: _____ Phone: _____

Relation to patient: _____

Parent/Guardian's Name: _____

Phone: (c) _____ (w) _____ (h) _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____

☐**Cancellation Policy**: You and your family are very important to us. As an Integrative Medical practice we are dedicated to providing the highest competency of healthcare and education. We hope you understand the reason for this cancellation policy.
If you cannot, or choose not to keep a routine appointment, we kindly ask for a 24-hour cancellation notice for follow-up appointments. A 72-hour notice is requested for an initial consultation.
If a cancellation is **not** made, you will be charged 50% of the first missed appointment fee. For any subsequent missed appointments, you will be charged the full amount for the time reserved. We do understand that there are extenuating circumstances; a simple phone call is requested to avoid these charges. Please be advised that this fee cannot be billed to your insurance carrier.

I understand and agree to the above policies:

Name: _____ Date: _____