Enrollment Application

Bridging the Gaps

To complete this enrollment application, you will need the following information:

- **Guarantor**
- **Health Insurance**
- **Doctors**
- **Medication list**

Note: Copies of the insurance cards are needed on file. While our services are not reimbursed by insurance, this information is needed to facilitate ordering services by other providers that may be reimbursed by insurance.

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Patient Demographics

* Patient

Name

Date of Birth

Address

Address 2

City

State -- select state --

Zipcode

Email Address

Phone Number

Alternate Phone Number

Who referred you to Bridging the Gaps?

- ◯ Dwana Bush, M.D.
- ◯ Ayesha Shaikh, M.D.
- ◯ Brandon Paritz, D.O.
- ◯ Maryanna Teilhaber
- ◯ Other

Is someone other than the patient completing this enrollment application? Patient may skip this question

Name, if other than patient	
Relationship to patient	
Your Phone Number	
Your Email	

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Important Contacts

Guarantor: A guarantor is the person responsible for paying patient's invoices. Name and email address are required below.

* Guarantor's Relation to Patient

If Other (please specify)

* Guarantor Information

Name	
Company	
Address	
City	
State	-- select state --
ZIP Code	
Email Address	
Phone Number	

Healthcare Power of Attorney

* Healthcare Power of Attorney's Relation to Patient

If other, please specify

Healthcare Power of Attorney

Name	
Company	
Address	
Address 2	
City	
State	-- select state --
ZIP Code	
Email Address	
Phone Number	

Principal Care Coordinator/ Caregiver

* Principal Caregiver's Relation to Patient

If other, please specify

* Principal Care Coordinator/ Caregiver

Name	
Company	
Address	
Address 2	
City	
State	-- select state --
ZIP Code	
Email Address	
Phone Number	

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Health Insurance

Healthcare Insurance Policy

Include the Insurance name and member ID for each policy you hold.

Please Note: Copies of the insurance cards are needed on file. While our services are not reimbursed by insurance, this information is needed to facilitate ordering services by other providers that may be reimbursed by insurance.

Primary insurance name	
Primary insurance policy number	
Secondary insurance	
Secondary insurance policy number	
Tertiary insurance name	
Tertiary insurance policy number	

Attach copy of primary insurance card

Choose File Choose File No file chosen

Attach a copy of secondary insurance card

Choose File Choose File No file chosen

Attach a copy of tertiary insurance card

Choose File Choose File No file chosen

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Current Doctors

Please take time to list any providers who are actively treating you.

Provider #1

Name	
Cellphone	
Address	
Address 2	
City	
Name of best contact in office	
Office Phone	
Office Fax	
Email Address	
Date Last Seen	

Provider #2

Name

Cellphone

Address

Address 2

City

Name of best contact in office

Office Phone

Office Fax

Email Address

Date Last Seen

Provider #3

Name

Cellphone

Address

Address 2

City

Name of best contact in office

Office Phone

Office Fax

Email Address

Date Last Seen

Provider #4

Name

Cellphone

Address

Address 2

City

Name of best contact in office

Office Phone

Office Fax

Email Address

Date Last Seen

Provider #5

Name

Cellphone

Address

Address 2

City

Name of best contact in office

Office Phone

Office Fax

Email Address

Date Last Seen

Provider #6

Name

Cellphone

Address

Address 2

City

Name of best contact in office

Office Phone

Office Fax

Email Address

Date Last Seen

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Hospital, Medications, & Pharmacy

What is your preferred Emergency Room?

What is your preferred Hospital?

When was your last hospitalization?

* Please share your recent medical history.

* List your active Medical Problems

1.
2.
3.
4.
5.
6.
7.

List your allergies or drug intolerances

1.
2.
3.
4.
5.
6.
7.

List your recent lab results

1.
2.
3.
4.
5.
6.
7.

* List your active medications

1.
2.
3.
4.
5.
6.
7.

Is there additional health information you want to share?

My Local Pharmacy

Company
Address
City/Town
State/Province -- select state --
ZIP/Postal Code
Fax Number
Phone Number

My Mail-order Pharmacy

Company
Address
City/Town
State/Province -- select state --
ZIP/Postal Code
Fax Number
Phone Number

Durable Medical Equipment & Services

Check all that apply

- [ ] Bedside commode
- [ ] Hospital bed
- [ ] Lockbox/combination lock
- [ ] Medic alert
- [ ] Occupational Therapy
- [ ] Oxygen
- [ ] Physical Therapy
- [ ] Rollator
- [ ] Walker
- [ ] Wheelchair

Other (please specify)

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Advanced Beneficiary Notice & Billing

I understand that Bridging the Gaps services provided by Dr. Bush and Dr. Shaikh are not covered by any health insurance plans or Medicare and will be billed at a rate of $250 per hour.

Invoices will be sent on the first and fifteenth of the month electronically.

Payments will be made by electronic payment or check to The Integrative Health Institute (289 Jones Dr, Roswell GA 30075) within 15 days of date of invoice.

* Please confirm your acceptance of our billing terms.

- [ ] I understand and accept the costs of services.

For a list of what to expect, after you submit your enrollment application, go to https://www.livingfullyfinishingwell.com Enroll page and scroll down to the Getting Started section.