

Address:  
913 W Canfield Ave  
Coeur d'Alene, Idaho 83815

Phone: 1-208-957-7808  
Fax: 1-949-695-2456



## Patient Registration Packet

Welcome To Mind And Body Restored and thank you for scheduling your appointment. Our providers and staff look forward to helping you reach your health goals!

### Require Information To Bring On Visit

- Insurance card(s) OR a CLEAR copy of the FRONT and BACK of all your insurance card(s).
  - Including Supplemental insurance cards
- Your driver's license or some other form of legal picture ID.
- Working Email Address
- Phone number that accepts text messages and or voice mails

### Online Patient Portal

Mind And Body Restored offers an extensive online patient portal. The portal allows for viewing your medical history, updating demographics and insurance information, direct communications with providers and staff. ***It is very important that we have an email address that will be sent a link for you to sign up on the online patient portal.***

Access the online patient portal directly from [www.mindbodyrestored.com](http://www.mindbodyrestored.com) or following the direct link here <https://portal.kareo.com/pp-webapp/app/new/login>

For instructions on using the online patient portal please review the document MBR\_Patient\_Portal\_Experience which can be accessed by:

- Going to website [www.mindbodyrestored.com](http://www.mindbodyrestored.com)
- Select Patient Forms
- Scroll down and select Patient Forms
- Select Forms on the top of the screen
- Choose MBR\_Patient\_Portal\_Experience

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### Patient Information

First Name	
Middle Name	
Last Name	
Street Address	
Appt/Unit/Slot	
City	
State	
Zip Code	
Mobile Phone	
Home Phone	
Work Phone	
Email	
Employer	
Work Address	

May we leave a voicemail and or text message (Leave unchecked if no)

Mobile Phone	<input type="checkbox"/>	Yes To Voicemail	<input type="checkbox"/>	Yes To Text Message
Home Phone	<input type="checkbox"/>	Yes To Voicemail	<input type="checkbox"/>	Yes To Text Message
Work Phone	<input type="checkbox"/>	Yes To Voicemail	<input type="checkbox"/>	Yes To Text Message

### Emergency Contact Information

First Name	
Middle Name	
Last Name	
Street Address	
Appt/Unit/Slot	
City	
State	

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Zip Code	
Mobile Phone	
Home Phone	
Work Phone	
Email	
Employer	
Work Address	

**Guardian And/Or Financial Responsibility**

*Only complete if patient/client is under 18 years of age*

First Name	
Middle Name	
Last Name	
Street Address	
Appt/Unit/Slot	
City	
State	
Zip Code	
Mobile Phone	
Home Phone	
Work Phone	
Email	
Employer	
Work Address	

**Pharmacy Information**

Name	
Phone	
Fax	

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### Signature and Date

My Signature below signifies that I or my authorized representative have read and agreed to all of the terms in following documents:

- Patient HIPAA Notice
- Patient HIPAA Acknowledgment
- Patient Contract Consent
- Patient Registration Packet (This document)
- Patient Office Policies
- Patient No Show Policy

All of these forms can be access through the website [www.mindbodyrestored.com](http://www.mindbodyrestored.com) at any time and through the online patient portal.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name

Legally Authorized Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name

Relationship To Patient

If the patient refused or was unable to acknowledge the Privacy Notice, please explain why: