Natural Family Health Care, Inc

www.doctorkeppel.com

Name: _____

Address:_____

City: _____ State: _____ Zip: _____

Primary Phone #:_____ Alternate Phone #:_____

Email:_____

Date of Birth: _____ Gender: M ☐ F ☐ SSN: _____

Occupation: _____ Employer: _____

In case of an emergency, please contact: _____

Phone: _____ Relationship: _____

How did you hear about our office? _____

_____

Would you like to be added to our email list for information regarding:
Details on specials and classes? Yes ☐ No ☐
Dr. Keppel's Nutritional newsletter? Yes ☐ No ☐

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and me. Natural Family Health Care, Inc., will prepare any necessary reports and forms to assist me, as allowed in office policy. I authorize the insurance carrier to pay all insurance benefits to Natural Family Health Care, Inc. directly. I clearly understand and agree that all services rendered to me are my personal responsibility. If this financial agreement is not paid when due, I agree to pay all reasonable costs of collections, including reasonable attorney's fees.

Signature: _____ Date:_____

Natural Family Health Care, Inc.
8791 Wolff Ct. Ste 140 Westminster, CO 80031
PH: 303-427-2414 | FX: 303-427-5719