

**Andrew Cook M.D.**  
**Mark Howard, D.O.**  
Linda Mavity N.P.  
Lene Joy, RNP



15055 Los Gatos Blvd., Suite 250  
Los Gatos, CA 95032  
Tel (408) 358-2511  
Fax (408) 358-1009  
www.VitalHealth.com

## Confirmation of Appointment

Welcome to Vital Health Institute. We look forward to seeing you as a new patient.  
We have reserved time in the office for you on:

at \_\_\_\_\_ am/pm. Please arrive 15 minutes early!

If you have insurance coverage, it is important to remember to bring your insurance card to your appointment to verify coverage. Patients with no proof of insurance or Blue Shield PPO insurance will be asked to pay 100% of the fees the day of the office visit.

Also, please bring the bottles, tubes or jars of any medications, over-the-counter medications or supplements that you take on a regular basis.

Many of our patients suffer from environmental sensitivities; please avoid wearing any perfumes, lotions or hair products with a fragrance when you have appointments at VHI. Thank you.

The fee for your new patient exam and consult is \$415. We collect one half (\$207.50) at the time of service for most insurance companies. This does not include other services such as labs or ultrasounds (see VHI Policy for Ultrasound Procedures). We will submit the required paperwork to your insurance company on your behalf.

Please complete and return our forms:

- 1) Patient Registration Form (1 page),
- 2) Patient Questionnaire (13 pages), and
- 3) Previous Operation Reports and/or other relevant medical records via mail, email or via facsimile (408.358.1009) at least 7 days prior to your office visit. The appointment will need to be rescheduled we do not have records at least 7 days prior unless prior arrangements have been made.

I am providing my credit card information so that Vital Health can charge \$200 to hold my new patient appointment. I understand that the funds will be applied to the charges that I will incur the day of my office visit.

**If I cancel within one week or do not arrive for my appointment I will forfeit the \$200 deposit.**

Patient Name: \_\_\_\_\_

Name on Card: \_\_\_\_\_

Credit Card: Visa/MC/DISC #: \_\_\_\_\_

Exp Date: \_\_\_\_\_ Billing Zip Code: \_\_\_\_\_ Code: Code: \_\_\_\_\_

If you have any questions regarding this information, please call us at 408-358-2511