

PATIENT INFORMATION

Patient Name _____ Home Phone _____
SSN _____ Male ___ Female ___ Birthdate _____ Cell Phone _____
Address _____ City _____ State _____ Zip _____
Circle living situation: Minor Single Married Separated Divorced With Companion Widowed
Patient's or parent's employer _____ Work phone _____
Business address _____ City _____ State _____ Zip _____
Spouse or parent's name _____ Employer _____ Work phone _____
Who may we thank for referring you? _____
Person to contact in case of emergency _____ Phone _____

INSURANCE INFORMATION

Medicare Number _____
Primary Ins Co _____
Address _____
Policyholder's Name _____ Birthdate _____
Relationship to Patient _____ Self _____ Spouse _____ Child _____ Other _____
Policy /Subscriber ID # _____ Group # _____
Effective Date _____ Deductible _____
Policyholder's Employer's Name _____ Telephone# _____
Secondary Ins Co _____
Address _____
Policyholder's Name _____ Birthdate _____
Relationship to Patient _____ Self _____ Spouse _____ Child _____ Other _____
Policy/Subscriber ID # _____ Group # _____
Effective Date _____ Deductible _____
Policyholder's Employer's Name _____ Telephone # _____

RESPONSIBLE PARTY MUST SIGN (must be at least 18 years of age)

That undersigned hereby authorizes the release of any information to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered, or for services to be rendered without obtaining my signature on each and every claim to be submitted by myself and/or dependents, and that I will be found by this signature as though the undersigned had personally signed the particular claim.

Please remember that insurance is considered a method of reimbursing the doctor for services rendered, and not a substitute for payment. It is your responsibility to pay any deductible amount, co-insurance, out of network %, and/or any other balance not paid by your insurance company. If your balance becomes 75 days past due with no financial agreement made with our office, we will turn it over for collection. Most insurances do not cover "Alternative or Holistic" portion of the services and only some insurances such as Medicare do not cover annual physicals. Please check with your insurance policy for the details of your specific plan.

Payment types accepted: 1.) CASH 2.) CHECK 3.) VISA OR MASTERCARD

Signature of Patient or Responsible Party Date