

Patient Information Form

Phone Intake Form

Who referred you _____

Mr. Mrs. Ms. Miss

Patient Name: (Last) _____ (First) _____ (MI) _____

Street Address:

Marital Status:

S M D W

City: _____ State: _____ Zip: _____

Telephone H W C: _____

Date of Birth:

Telephone H W C: _____

E-Mail Address:

Social Security Number:

Insurance Company:

Name of Spouse:

Member Number/ ID:

Subscriber's Name if not same:

Group Number:

Subscriber's Date of Birth

Date of Initial Appointment:

Date:

Check if Paper Work has been Mailed

Before your visit, please call your insurance company to check your benefits

Date: _____ Customer Service Rep: _____ Effective Date: _____

Deductible: _____ Co-Pay _____ Insurance Maximum _____

Met as of today: _____ After Co-Pay Insurance Pays _____ Patient Maximum _____

Naturopathic Coverage? Yes ___ No ___

Notes:

Financial Agreement and Authorization For Treatment:

- ◆ I understand and agree that my health insurance is an arrangement between my insurance carrier and myself; that all services furnished to me are charged directly to me and that I am personally responsible for payment at the time of service.
- ◆ I authorize treatment and agree to pay all charges at the time of service. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within 30 days of billing.
- ◆ It is agreed that payments will not be delayed or withheld because of any insurance coverage or pendency of the claims thereon. A copy of this agreement is as valid as the original. I also agree to pay for any missed appointments that were not canceled or rescheduled at least 24 hours in advance.

Signature of Patient or Guardian: _____

Date: _____