Patient and Insurance Information Form

Please take a moment to complete this form in its entirety, and sign at the bottom.
This will enable smooth insurance billing and reimbursement for our office. Thank you!

Patient Information

Name:	Date of Birth:	Gender: M F
Address:	Phone (home):	
State: Zip:	Phone (work):	
	Phone (cell):	
Employer:	□Single □Partnered □Married □Other	
Email:		

Primary or Medical Insurance

Plan Name:	ID # (include prefix):
Plan Address (back of card):	SS# (if different from ID#):
	Group #:
	Plan Phone# (back of card):

Insured's Information, if other than self: (do not skip this section!)

Name:
Address:
Date of Birth:
Relationship to Insured: □ Self □ Child □ Spouse □ Other

PIP, L&I, or Secondary Insurance (complete this section if you have a work or auto injury)

Is your condition injury related? □ No □ Yes, auto accident □ Yes, work related	
Plan Name:	ID # or SS# (include prefix):
Plan Address (back of card):	Claim #:
	Adjuster:
	Date of Injury:
Name of Insured:	Plan Phone #:

Plan / Coverage Details

Orthotic coverage? Yes No Limits:

Co Pay: $		Co-insurance payment:		
Annual Deductible: $		Eligibility confirmed: □ Yes □ No		
Yearly Max for Prevention visits		$	# of visits:	
Coverage Limits	**$ Amount**	**# of Visits**	**Referral or Prescription Needed?**	
Naturopathic	$	#	□ Yes □ No □ Self Ref. OK	
Physical Medicine	$	#	□ Yes □ No □ Self Ref. OK	
Acupuncture	$	#	□ Yes □ No □ Self Ref. OK	
Massage	$	#	□ Yes □ No □ Self Ref. OK	
Have you gotten the needed referrals or prescriptions?			□ Yes □ No	I confirmed coverage with (name):

Referring Physician's Name:______________________________ Phone:____________________

I agree to the release of any medical information my health insurance may need in order to process payment. I assign such benefits to be paid to __________________. I understand that I am ultimately responsible for all fees incurred, (for instance, if my insurance coverage expires or denies payment). I take full responsibility for knowing my insurance coverage and limits, and will work toward the goal of helping my practitioner to be fully reimbursed for her services.

Signature ____ Date____________________