CONFIDENTIAL PATIENT INFORMATION

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_Birth Date \_\_\_\_\_\_\_\_\_\_\_\_ Sex **M F**

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ APT# \_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_Zip\_\_\_\_\_\_\_\_

Home Phone (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it ok to leave personal medical information on your message machine? Yes\_\_\_\_\_\_ No\_\_\_\_\_

Which phone number is ok to call and leave messages on\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Student? **Y N** **Full** or **Part time**

SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Driver's License #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status S M D W Number of Children \_\_\_\_\_Ages\_\_\_\_\_\_\_\_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our Clinic? (If phone book, please specify which one) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Would you like to receive information via email? Y N

INSURANCE INFORMATION

Dr. Allen is a preferred provider for Premera Blue Cross, Aetna, Cigna, First Choice (GroupHealth Options) and Lifewise. Other plans may cover a percentage of the visit. Please call the number on the back of your insurance card to understand your plan’s coverage. Thank you.

Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of subscriber \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and date of birth \_\_\_\_\_\_\_\_\_\_ Relationship to patient\_\_\_\_\_\_\_

Subscribers address if different from patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Primary Care Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_

**Please call your insurance company (number on back of card) ask for the following information:**

Do you have medical insurance with Naturopathic Medical and Acupuncture Coverage? **Y N**

Do you need a referral before coming to our clinic? **Y N** (You are responsible for obtaining a referral) Is there a deductible?  **Y N** (If yes)Individual $\_\_\_\_\_\_\_Family $\_\_\_\_\_\_\_ Amount paid to date $\_\_\_\_\_\_\_

Is there a Co-Pay? Y N $\_\_\_\_\_\_\_ What percent will your policy cover for treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE BRING YOUR CARD WITH YOU SO WE CAN MAKE A COPY FOR YOUR FILE**

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and myself. I hereby authorize the undersigned physician the right to furnish medical information to my insurance carriers concerning this illness or accident. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable. Furthermore, any charges, fees, or court costs incurred as a result of collection efforts will be added to my account balance. Permission is hereby given for any medical treatment and any diagnostic procedures required for my health care, or (when patient is a minor child) for the health of my minor child.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient's Signature Parent or Guardian's Signature Date

CLINIC POLICY REQUIRES PAYMENT AT THE TIME OF SERVICE

We gladly accept: Cash • Check • Visa • MasterCard