

NURTURING HEALTH ACUPUNCTURE  
316 E. Fourth Plain Blvd. Ste A4  
Vancouver, WA 98663  
360.696.4480

**Patient Information Form**

Name: \_\_\_\_\_ SS# \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street, Apt #) (City) (State) (Zip)

E-mail address \_\_\_\_\_ Home Phone: \_\_\_\_\_ 0 Male 0 Female  
Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ 0 Single 0 Married 0 Separated 0 Divorced 0 Widowed 0 Other

Employer & Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Spouse or Parent: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address if different: \_\_\_\_\_

**In Case of Emergency**

Relative to contact (other than spouse) \_\_\_\_\_ Phone: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Cell: \_\_\_\_\_

**Who referred you to our Clinic?**

Person's or Dr's Name: \_\_\_\_\_ Phone Book \_\_\_\_\_ Other \_\_\_\_\_

**Insurance Information**

Primary Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Birth Date of Insured: \_\_\_\_/\_\_\_\_/\_\_\_\_

Policy/ID# \_\_\_\_\_ Group # or Employer: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ SS# \_\_\_\_\_

Name of responsible party (if different than insured) \_\_\_\_\_

**Patient's or Authorized Person's Signature**

As a service to our patients we will submit charges for medical treatment to our patient's insurance company. Therefore, your signature below authorizes the release of any medical or other information necessary to process your insurance claims which the insurance company may request concerning your present illness or injury with the exception of those test results which require specific authorization. You understand this office cannot accept responsibility for negotiating a settlement on a disputed claim. Some services provided are not covered by insurance to which I acknowledge I am financially responsible for all charges, and these will be paid at the time of service. Occasionally, even though coverage was verified before the medical services were provided, the insurance company may decline the claim. Therefore, you also agree to be responsible for payment of services in the event your insurance company, Workers Compensation claim or attorney doesn't agree to pay for these services, or does not pay the claim in full.

Signed: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

PATIENT INSURANCE VERIFICATION  
CLINIC: Nurturing Health Acupuncture

PATIENT NAME: \_\_\_\_\_

SOCIAL SECURITY # OF PATIENT: \_\_\_\_\_ D.O.B. \_\_\_\_\_

NAME OF INSURED: (If different then patient) \_\_\_\_\_

SOCIAL SECURITY # OF INSURED: \_\_\_\_\_ D.O.B. \_\_\_\_\_

NAME OF INSURANCE COMPANY: \_\_\_\_\_

INSURANCE PHONE# & BILLING ADDRESS: \_\_\_\_\_

\_\_\_\_\_

MEMBER ID#: \_\_\_\_\_ GROUP#: \_\_\_\_\_

*FOR VERIFICATION USE ONLY*

DATE OF VERIFICATION: \_\_\_\_\_ CUSTOMER SVC. REP.: \_\_\_\_\_

COVERAGE:  YES  NO REFERRAL REQ.:  YES  NO

AUTHORIZATION REQ.:  YES  NO AUTH OR REF #: \_\_\_\_\_

SUBJECT TO PRE-EXISTING:  YES  NO

EDC: \_\_\_\_\_ COPAY: \_\_\_\_\_ % OF COVERAGE: \_\_\_\_\_

DEDUCTIBLE: \_\_\_\_\_  C.Y.  A.D. MET YTD: \_\_\_\_\_

MAX \$ PER YEAR: \_\_\_\_\_ MAX # OF VISITS: \_\_\_\_\_

OUT-OF-POCKET MAX: \_\_\_\_\_ % COVERAGE: \_\_\_\_\_

CHART NOTES REQ.:  YES  NO TREATMENT PLAN REQ.:  YES  NO

VERIFY INSURANCE BILL TO AND ADDRESS:

\_\_\_\_\_

\_\_\_\_\_

ADDITIONAL INFO: \_\_\_\_\_