Liz Cavin Naturopathic Doctor

INSURANCE INTAKE FORM

Patient Information:

Patient Name: _____ Cell: _____

Last First M.I. Home #: (If different) _____

Home Address: _____ _____ _____ _____

PO Box/Street City State Zip

Birth Date: ___/___/_____ Occupation: _____ Work Phone: _____

Spouse/Partner: _____ Birth Date: ___/___/_____ Social Security #: _____

Responsible Party: _____ Relationship to Patient: _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____

Address: _____ _____ _____ _____

PO Box/Street City State Zip

Policy ID #: _____ Group #: _____

Primary Insurer's Name: _____SSN: _____ Birth Date: _____/_____/_____

I authorize the release of any medical records or other information necessary to process my claim and authorize payment of insurance benefits to Dr. Liz Cavin for services rendered.

HIPAA: I acknowledge I have been offered or have received a "Notice of Privacy Policies" that provides a complete description of information uses and disclosures permitted under law.

Assignment of Benefits/Financial Agreement: I have read and signed the Financial Policy of Liz Cavin Naturopathic Doctor. I hereby authorize Liz Cavin Naturopathic Doctor to release all information necessary to process claims. I authorize payment of medical benefits to Liz Cavin Naturopathic Doctor. I understand that I am financially responsible for all charges, whether they are covered by Insurance or not. In the event of default, I agree to pay all costs of collection and reasonable attorney fees. I further agree that a photocopy of this document shall be valid as the original.

Patient Printed Name: _____ Responsible Party: _____

Signature: _____ Date: _____

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