## PATIENT INFORMATION

Name: ______________________________

Address: ______________________________

______________________________

Telephone: ____________________ Cell: ______________________________

Date of Birth: ______________ Social Security No.: ____________________

Driver's Lic. No. ______________________ Email: ______________________

Employer: ______________________________

Employer Address: ______________________________

Occupation: _____________________ Work Phone: ______________

Referred By: ______________________________

In Case of Emergency: ______________________________

Will we be billing insurance? _____________

If yes, please provide the following information:

Name of Spouse/Responsible Party: ______________________________

Spouse/Responsible Party's Employer: ______________________________

Spouse/Responsible Party's Employer Address ______________________________

Spouse/Responsible Party's SSN: ____________________ Date of Birth: ____________

Primary: ______________________ Group/Plan No. ______________

Secondary: ______________________ Group/Plan No. ______________

## FINANCIAL POLICY STATEMENT:

We will bill your insurance for treatment received at our facility. You are responsible for payment of your estimated share at the time of your visit, including any co-payment, co-insurance or deductible. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to Catherine Aquino, L.Ac.

We must emphasize that as medical providers, our relationship is with you, and not your insurance company. As a courtesy, our office staff will call your insurance company to estimate your insurance benefits and coverage to the best of their ability. This is not a guarantee of coverage, and as the patient, you are ultimately responsible for knowing and understanding your insurance coverage and for the charges incurred at our facility. We cannot guarantee coverage or payment by your insurance company. We recommend that you also contact your insurance company to verify coverage on your policy.

We realize that temporary financial problems may effect timely payment of your account. If such problems do arise, please let us know so that we may assist you by setting up a payment plan as needed.

I, the undersigned, understand that if I am being seen for treatment/services not covered by my insurance carrier, I am responsible for the entire bill when services are rendered.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

For cancellation of appointments, we require that 24-hour notice be given. On less than 24-hour notice, you will be subject to a $45.00 late cancellation fee. For patients 15-30 minutes late you may be asked to reschedule your appointment or have a shortened session.

The above information has been read and explained to me. I understand my responsibility for the payment of my account.

Client/Patient/Guardian________________________________________Date_______