

## Patient's Insurance Information

Patient's Name: \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Gender: M F

Marital Status: Single Married Divorced Widowed Other

Employment: Employed F/T Student P/T Student Retired Other

### **Primary Insurance**

Insurance Company Name: \_\_\_\_\_

Insurance ID# \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber's (Primary insured's) Name: \_\_\_\_\_

Subscriber's date of birth: \_\_\_/\_\_\_/\_\_\_ Gender: M F

Subscriber's address (if different than patient's) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Relationship to patient: Self Spouse Parent Other

### **Secondary Insurance**

Insurance Company Name: \_\_\_\_\_

Insurance ID# \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber's (Primary insured's) Name: \_\_\_\_\_

Subscriber's date of birth: \_\_\_/\_\_\_/\_\_\_ Gender: M F

Subscriber's address (if different than patient's) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Relationship to patient: Self Spouse Parent Other

## Financial Agreement

I understand that I am financially responsible for all charges and agree to pay for services. I agree to pay co-pay at the time of service. If insurance does not pay a claim within 180 days, I understand that I am personally responsible for all charges. I also understand that it is my responsibility to know the details of my insurance benefits. I authorize Nourishing Life to release to my insurance companies any and all information necessary to process my claims. I further authorize that payment be made directly to Nourishing Life. I understand that if I cancel or reschedule an appointment with less than 24 hours notice that I will be charged a missed appointment fee. I understand my insurance company will not be responsible for this fee.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_