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 # _____ Phone # _____
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 # _____ Phone # _____
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:** _____