INSURANCE INTAKE FORM

Eli Andrew Stahl L.Ac.,LMP

PATIENT

Name_______________________________ Date of Birth___________________________

Address_____________________________ Phone[Home]__________________________

_________________________________ Phone[Work or Cell]__________________

Employer____________________________ E-Mail_______________________________

Single_____ Married_____ Other____

PRIMARY INSURANCE INFORMATION

Plan Name__________________________ ID#________________________________

Address_____________________________ Group#_____________________________

SECONDARY INSURANCE

Plan name__________________________

Address____________________________

____

INSURED INFORMATION[other than self]

Name_______________________________

Address_____________________________

____

Date of Birth_________________________

REFERRING PHYSICIANS NAME___________________________PHONE_________________

I AGREE TO THE RELEASE OF ANY MEDICAL INFORMATION MY HEALTH INSURANCE MAY NEED IN ORDER TO PROCESS PAYMENT. I ASSIGN SUCH BENEFITS TO BE PAID TO THE ABOVE NAMED PROVIDER. IN THE EVENT THAT MY INSURANCE COVERAGE EXPIRES OR DENIES PAYMENT, I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR ALL FEES INCURRED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.

SIGNATURE________________________________**DATE**___________________________