

Dr. Alice Holman, N.D., L.Ac.

Naturopathic Medicine and Acupuncture

1755 Prospector Ave., Park City, Utah 84060 Phone: 435-655-7243 Fax: 1-888-977-1975

CONFIDENTIAL PATIENT INFORMATION

Today's Date _____

Name _____ Age _____ Birth Date _____ Sex **M F**

Address _____ APT# _____ City _____ State _____ Zip _____

Cell Phone (____) _____ Work Phone (____) _____ Home Phone (____) _____

Is it ok to leave personal medical information on your message machine? Yes _____ No _____

Which phone number is ok to call and leave messages on _____

Email Address _____ Would you like to receive information via email? **Y N**

Employer _____ Occupation _____ Student? **Y N Full or Part time**

Marital Status **S M D W** Number of Children _____ Ages _____

Person to contact in case of emergency _____ Phone # (____) _____

Primary Care Physician _____ Phone # (____) _____

How did you hear about our Clinic? _____

INSURANCE INFORMATION

We require payment for your visit at the time of service. In the State of Utah, many insurance plans and health savings accounts will reimburse you for a percentage of your visits with Dr. Holman as an Out of Network provider. We will provide you with a receipt for your visit that you may submit to your insurance company. Please call the number on the back of your insurance card to understand your plan's coverage. Thank you.

Insurance Company _____ Name of subscriber _____

Subscribers address if different from patient _____

Please call your insurance company (number on back of card) ask for the following information:

Do you have medical insurance with Naturopathic Medical and Acupuncture Coverage? **Y N**

Do you need a referral before coming to our clinic? **Y N** (You are responsible for obtaining a referral) Is

there a deductible? **Y N** (If yes) Individual \$ _____ Family \$ _____ Amount paid to date \$ _____

Is there a Co-Pay? **Y N** \$ _____ What percent will your policy cover for treatment? _____

PLEASE BRING YOUR CARD WITH YOU SO WE CAN MAKE A COPY FOR YOUR FILE

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and myself. I hereby authorize the undersigned physician the right to furnish medical information to my insurance carriers concerning this illness or accident. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable. Furthermore, any charges, fees, or court costs incurred as a result of collection efforts will be added to my account balance. Permission is hereby given for any medical treatment and any diagnostic procedures required for my health care, or (when patient is a minor child) for the health of my minor child.

Patient's Signature

Parent or Guardian's Signature

Date

CLINIC POLICY REQUIRES PAYMENT AT THE TIME OF SERVICE

We gladly accept: Cash • Check • Visa • MasterCard