Dr. Alice Holman, N.D., L.Ac.
Naturopathic Medicine and Acupuncture
228 West 200 South, Suite 2B, Kamas, UT 84036 Phone: 435-615-2020 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.

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 to 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