PATIENT INFORMATION

Last Name____ First _________________________Middle ______________
_____Male _____ Female Date of Birth____
Address ____City_________________________St____ Zip_________
Home Phone (___)___________ Cell Phone (___)___________ Email ____
Employer____ Address ____
City ________________________________St_______ Zip_________ Phone_______________ Ext#_______________

RESPONSIBLE PARTY INFORMATION

(If different than Patient)

Responsible Party Last Name__________________________________ First_____________________________ M.I.____
_____Male _____ Female Date of Birth____
Address ____City______________________St_____ Zip_________
Home Phone: (___)____________ Cell Phone: (___)___________ Email: ______________________________________
Employer ________________________ Address ____
City __________________________________St_______ Zip_____________ Phone_____________________ Ext#_______

INSURANCE INFORMATION

Insurance Co._________________________ID#____ Group #____________________
Insurance Phone#___________________Subscriber's name___________________________Date of Birth_____________

SECONDARY INSURANCE INFORMATION

Insurance Co._________________________ID#____ Group #____________________
Insurance Phone#___________________Subscriber's name___________________________Date of Birth_____________

PERSONAL INJURY INFORMATION

Insurance ____ Insurance Phone# ________________________________
Policy# ___________________________________ Claim #____
Date of Injury ______________________ Adjuster____ EXT.____________
Has this injury been reported to your Insurance? _____ yes _____ no

I agree, if I do not give 24 hours notice of cancelling my appointment I will be billed $50.00 ______________(initial)
By initialing here ______________ I am acknowledging receipt of the NOTICE OF PRIVACY PRACTICES for this office.

By signing this intake, I authorize therapy necessary for treatment and agree to pay all fees and charges for such treatment if coverage is not available. I also authorize the release of any medical or other information to Puget Sound Medical Billing, necessary to process insurance claims related to treatment. I request all insurance payments be sent directly to this Provider for all services rendered.

____ ____________________________________

Signature (Parent or Guardian, if applicable) Date

Anderson Natural Medicine, LLC, Dr. Nicole Anderson, ND, 16923 96th Ave. NE, Bothell, WA 98011-1937
Phone:425-429-2334 Fax:425-483-7332 Billing:425-503-6739 Billing Fax: 425-836-8629
Email: drnicoleanderson@gmail.com
Billing email: Laura@psmbilling.com