	IEW PATIENT INFORMATION
Patient Name:	Date of Birth:
Mailing Address:	Cell Phone:
City/State/Zip:	Home Phone:
Marital Status: S M W SEP D	
PA	IENT/EMPLOYER INFORMATION
Patient's Occupation:	
Patient's Employer:	Work Phone No:
Emp. Address:	<del></del>
City/State	Zip:
	SURED PERSON (If Not Patient)
Name:	Phone No:
Mailing Address:	
City/State	Zip:
	INSURANCE
□ None	
□ PPO or □ HMO (name):	Medicare ID#:
Primary Insurance:	Policy/ID#: Group:
Subscriber's Name:	Relationship:
Secondary Insurance:	Policy/ID#: Group:
Subscriber's Name:	Relationship:
- Cubestiber e Hame.	REFERRED BY
☐ Patient (name)	☐ Friend/Relative
□ Doctor (name)	☐ Phone Book
	T Hole Book
be paid for AT THE TIME OF SERVICE Associates will provide a superbill with the insurances will not cover any services at usual and customary" and may not be coutside facility. Therefore, if needed, I will amount at the time of service. Nutritional insurance companies and, if purchased	PROVIDED; Health Associates does not bill insurance companies. He appropriate medical codes for my insurance company for reimbursement. He ealth Associates. I also understand that some of my testing is considered fered by my insurance company. Most laboratory services are performed at receive a separate bill for them. I understand that I will be expected to pay supplements recommended frequently as therapy are usually not covered ere, are not taxed. I can pay by Visa, MasterCard, Discover Card, Amerial consultation is \$365. The total cost of the visit is usually \$500-\$600 included care pricing is different than listed above.
Also, by signing below, I authorize releated Health Associates.	e of information relating to any claims submitted to insurance companies
not have physicians on call in the evening or urgent problem, we recommend you go	24-hour acute care facility, although we do have an answering service. We or on weekends. If you cannot get through to us and you have an emerge immediately to your nearest walk-in clinic or Emergency Room. Please conffice hours regarding your problem if you are seen at another facility.
X	

Date

Signature