CONFIDENTIAL PATIENT INFORMATION

Patient Name:_____ Today's Date:_____

Date of Birth:_____ Sex: ❑Male ❑Female ❑Other:_____

Marital Status: ❑Single ❑Married ❑Domestic Partnership ❑Separated ❑Divorced ❑Widowed

Street Address:_____

City:_____ State:_____ Zip:_____

Mailing Address if different:_____

Cell Phone:_____ Home Phone:_____

Work Phone:_____ Extension:_____

E-mail Address:_____ OK for appointment reminders? ❑Yes ❑No

Occupation/Job Title:_____ How long?_____

My household contains: ❑myself ❑spouse or partner ❑children: #____ ❑housemate(s)#____ ❑pet(s) #____

Spouse/Partner Name:_____ Phone Number:_____

Emergency Contact (if other than spouse or partner):_____

Emergency Contact's Phone Number:_____ Relationship to you:_____

If patient is a minor, signature of Parent/Legal Guardian: _____

How did you hear about our clinic?_____

Insurance Information *Insurance billing is a courtesy we extend to our patients. However, our relationship is with you, and you have a relationship with your insurance company. If your claim is denied, you are financially responsible for the bill in full, and we expect payment in a timely manner.*

Is your health insurance provided by your employer or someone else's? ❑mine ❑someone else's

Please fill in the following information **for the person whose job provides your insurance**:

Insured's Name:_____ Insured's Date of Birth:_____

Your Relationship to Insured:_____

Insured's Employer:_____

Health Insurance Company:_____

Policy Number:_____ Group Number:_____

Date Policy in Effect:_____ Annual Renewal Date:_____

Annual Deductible (if any):_____ Deductible met this year?_____

Patricia Hallam, LAc, LLC 1675 SW Marlow Ave, Suite 307, Portland, OR 97225 (503) 421-9339

FINANCIAL POLICY AGREEMENT

- ❑ **PRIVATE PAY PATIENTS**

I agree to provide full payment for services I receive at the time they are rendered, with all applicable time-of-service discounts applied. Under special circumstances, I may make arrangements with my provider to have my services billed to me. I understand that any such outstanding balance will be due within 30 days of receiving a billing statement. Balances not paid within 30 days may be charged a rebilling fee. If a balance is not paid within 90 days, and my account is sent to a collection agency, I understand that I am responsible for any additional collection and/or attorney fees related to my delinquency.

- ❑ **HEALTH INSURANCE PATIENTS**

I understand that insurance billing is a courtesy that this office extends to its patients, and that should I ask my provider to bill my insurance company for me, I will ***not*** receive any time-of-service discount. I understand that I may obtain a time-of-service discount by paying for services at the time they are rendered and then submitting the insurance superbill my provider will give me to my insurer to obtain reimbursement directly from them. I understand that it is to my benefit to confirm my specific insurance coverage terms and limits prior to seeking treatment by calling my health insurance customer service representative. I understand that it is customary for many insurance companies not to cover supplements or herbs, and therefore agree to pay for these materials at the time of service. In the event my insurance company does cover these items, I understand that I may request a receipt to use to request reimbursement from my insurance company. Except in the case of In-Network coverage under a contracted plan, I agree to accept full responsibility for all amounts not paid for by my insurance company and agree to pay the treating provider(s) for all services provided to me which the insurance company denies due to their usual and customary policy or for other reasons. I understand that any such balances are due within 30 days of receiving a billing statement. It is my responsibility to research possibilities of any further reimbursement from my insurance company for any services or amounts denied.

- ❑ **MOTOR VEHICLE COLLISIONS**

It is Oregon state law that in order to have my services paid for by my insurance company, I must provide the treating provider with my insurance company information for billing purposes. If I do not provide this information I agree to the terms set forth under PRIVATE PAY PATIENTS. If my insurance company has not made a payment within 45 days of the time service is rendered, I will assist this office in resolving my account issues.

- ❑ **ON THE JOB INJURIES**

I agree to act in accordance with all state laws pertaining to workers' compensation cases. If my insurance company has not made a payment within 45 days I will assist this office in resolving my account issues.

CANCELLATION POLICY

I understand that there is a fee of $35 for missed or canceled appointments without 24 hours notice, that this fee is my responsibility and cannot be billed to any insurance.

I have read, and agree to, the office and financial policies above.

Signed _____ **Date** _____