Patient Insurance/Contact Information

Primary Insurance Information :

Name of Insurance Company: _____

Provider Customer Svc #: (_____)_____Benefits/Claims #: (_____)
_____

ID # (member #): _____ Group or Plan #:
_____

Insured Party's Name: _____ Relationship to patient:
_____

Insured Party's Date of Birth: _____ Insured Party's SS#: _____

Insured Party's Employer: _____ Insured Party's phone # _____

Secondary Insurance (if applicable):

Name of Insurance Company: _____

Provider Customer Svc #: (_____)_____Benefits/Claims #: (_____)
_____

ID # (member #): _____Group or Plan #:
_____

Insured Party's Name: _____ Relationship to patient:
_____

Insured Party's Date of Birth: _____ Insured Party's SS#: _____

Insured Party's Employer: _____ Insured Party's phone # _____

Note: It is a good idea to call the member services number on the back of your insurance card to confirm that you are covered by your insurance company. Ask if you have the "medical nutrition benefit" under "preventative care." If not, ask if it is covered under "medical care."

OFFICE POLICIES

Financial Disclosure & Disclaimer - In order to provide you with the best possible care, the following office policies are established:
Confidentiality - All sessions are held in strict confidence. In order to improve the quality of your care, a HIPAA release is obtained to permit patient care coordination with your physician or psychotherapist.
HIPPA Information: I hereby give permission to LWELL, LLC to disclose and discuss any information related to my medical condition to/with the following:

Contact: _____ Relationship to patient: _____

Home #: (_____)_____Alternate phone #:
(_____)_____

The duration of this authorization is indefinite unless otherwise indicated in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information

1) I am financially responsible for services rendered.
2) I have received and agree to the office policies, including the no show policy
3) I understand the LWell HIPPA privacy notice.

NAME_____

SIGNATURE OF PATIENT/GUARDIAN _____ **DATE** _____