PATIENT INFORMATION FORM

Michelle Kwok, LMT

DATE OF ACCIDENT:	**STATE ACCIDENT OCCURRED IN:**
NAME OF REFERRING PHYSICIAN: **PHYSICIAN'S OFFICE ADDRESS:** **PHYSICIAN'S PHONE NUMBER:**	 **NPI:**

PATIENTS NAME (as shown on insurance card)

LAST NAME , FIRST NAME , MIDDLE INITIAL

____

GENDER: Male ____ Female ____ DRIVER'S LICENSE #: _______________________

BIRTH DATE: _______________ MARITAL STATUS: Single ____ Married ____ Other ____

PATIENT'S ADDRESS: ____

CITY: _________________________________ STATE: __________ ZIP CODE: __________

HOME/CELL PHONE: _______________________ WORK PHONE: ____________________

PATIENT'S EMPLOYER: ______________________________________

EMERGENCY CONTACT PERSON__________________________ TELEPHONE: __________

PATIENT SIGNATURE: ___________________________________

DATE:__________________

INSURANCE PLAN AND RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM ABOVE)

INSURED'S CLAIM NUMBER: __________________________ POLICY #:________________

INSURANCE COMPANY NAME:

____

INSURANCE COMPANY BILLING ADDRESS:

____

ADJUSTER'S NAME ____

PHONE: ______________________ FAX: ____________________________

INSURED OR GUARANTOR'S NAME:

INSURED'S EMPLOYER: ___________________ EMPLOYER'S TELEPHONE: _____________

DID ACCIDENT OCCUR WHILE DRIVING A COMPANY VEHICLE? _________________________

INSURED'S DATA (if different from Patient): BIRTH DATE: ______________________________

GENDER: MALE __ FEMALE **__** RELATIONSHIP TO PATIENT: **___________________________**

PLEASE REVIEW THE INFORMATION YOU HAVE PROVIDED TO ENSURE THE CORRECT DATA FOR YOUR CHART AND BILLING INFORMATION. PATIENTS ARE RESPONSIBLE FOR KEEPING THIS DATA UPDATED WITH EACH VISIT TO ENSURE TIMELY BILLING AND COLLECTIONS.

Insurance is considered a method of reimbursing the PATIENT for fees paid to the practitioner and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not covered or reimbursed by your insurance carrier.

BY SIGNING THIS INFORMATION FORM, I HAVE BEEN INFORMED THAT IT IS MY RESPONSIBILITY TO CONTACT MY INSURANCE CARRIER TO VERIFY THAT ANY AND ALL AUTHORIZATIONS HAVE BEEN OBTAINED PRIOR TO THIS VISIT. I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT IN FULL FOR ALL SERVICES RENDERED REGARDLESS OF INSURANCE. IF THIS ACCOUNT IS ASSIGNED TO AN ATTORNEY FOR COLLECTION AND/OR SUIT, THE PRACTICE SHALL BE ENTITLED TO ATTORNEY FEES AND COSTS OF COLLECTION.

AUTHORIZATION OF INSURANCE BENEFITS: I AUTHORIZE INSURANCE PAYMENTS TO GO DIRECTLY TO Michelle Kwok, LMT. IF PAYMENTS ARE DEFAULTED TO ME, I AGREE TO PAY Michelle Kwok, LMT, FOR ALL MEDICAL SERVICES PROVIDED. I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO DETERMINE LIABILITY FOR AND TO OBTAIN REIMBURSEMENT OF ANY CLAIM. THIS ASSIGNMENT SHALL REMAIN IN EFFECT UNTIL REVOKED IN WRITING BY ME. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS THE ORIGINAL.

INSURED'S SIGNATURE: _________________________________DATE _______________

Michelle Kwok, 1660 NE 8th St, Bend, OR 97701 541-848-8607 WILL BE SUBMITTING THE CLAIM FOR SERVICES RENDERED TO YOUR INSURANCE CARRIER. WE ENCOURAGE YOU TO CONTACT Michelle Kwok LMT IF YOU HAVE ANY QUESTIONS OR PROBLEMS REGARDING YOUR VISIT.