



# Welcome to Advanced Integrative Medicine

<b>PERSONAL</b>	
Patient Name: _____	
Address: _____	
City/State/Zip: _____	
Social Security #: _____	
Gender: F / M	Marital Status: _____
Spouse's Name: _____	
Patient's Birthdate: ____/____/____	Age: _____
Home Phone: _____	Cell: _____
Work Phone: _____	Ext: _____
Email: _____	
Send Statement c/o: _____	
Address: _____	
City/State/Zip: _____	
Phone: _____	Relation: _____
Emergency Contact: _____	
Phone: _____	Relation: _____
May we ask how you were referred?	

<b>GUARANTOR</b>	
Policy Holder: _____	
Address: _____	
City/State/Zip: _____	
Social Security #: _____	
Gender: F / M Birthdate: ____/____/____	
Home Phone: _____	
Employer: _____	
Address: _____	
City/State/Zip: _____	
Work Phone: _____	
_____ <b>YES, I have completed/filed the necessary benefits form.</b>	
Insurance Co: _____	
Call Benefits @ (      )      -	
Contact: _____	Ext: _____
Group Name: _____	Group # _____
ID/Claim #: _____	
Patient is:    self    spouse    child    3rd party	
other: _____	

<b>CASE</b>			
Were you in an Auto Accident?	Injury Date: _____		
Were you in a Work related Injury?	Injury Date: _____		
Will you be utilizing medical benefits?			
NO Insurance	Insurance	____Fund	Auto/Accident Ins
Medicaid/Medical	Medicare	Government	Work Comp Ins
<i>Daily Activity/Occupation:</i>			
<i>My Primary Care Physician referred me for:</i>			
Doctor: _____		Specialty: _____	
Phone: _____		UPIN/ID#: _____	
Attorney: _____		Phone: _____	
<i>Treating Facility:</i>			
Employer: _____			
Address: _____			
Department: _____			
City/State/Zip: _____			
Phone: _____		Ext: _____	
Fax: _____			
Email: _____			

Please initial:	
____ <b>YES</b> , I will pay my portion at the time of service.	
____ <b>YES</b> , this office has my permission to copy my driver's license or photo ID for the sole purpose of identification and verification.	
<b>AUTHORIZATION &amp; ASSIGNMENT OF BENEFITS</b>	
<b>I authorize</b> the staff to perform any necessary services needed during diagnosis and treatment.	
<b>I authorize</b> the release of any medical information necessary to process and pay this claim. I authorize payment directly to <b>Advanced Integrative Medicine</b> of the "Health Benefits," "Medical Reimbursement" from a Third Party Payor and/or "Government Benefits" otherwise payable to me. I understand this office only accepts assignment when insurance pays directly.	
<b>I fully understand</b> when the insurance company verifies my benefits, it is not a guarantee or authorization to pay on claims submitted. I agree to pay my portion, plus any balance insurance does not reimburse for, at each visit. I agree to pay/settle any denied/unpaid claims. I understand all claims submitted by this office are my responsibility and require my participation to settle regardless of my insurance company or assignment of benefits.	
PRINT	
Patient/Guarantor -PRINT name	
x	/ /
Patient/Guarantor - signature	Date