Patient Policies and Billing

Name:______________________________Date of Birth:_______Social Security #:_________

Address:________________________________City:____________State:__Zip:________

Home #:_________________Work #:__________________Cell #:___________________

Email:______________________Occupation/Employer:______________________________

Primary Care Provider:________________________________#:____________________

Emergency Contact Person:______________________________#:____________________

Please indicate your preferred method(s) of contact for appointment scheduling and rescheduling:
Phone call ( ) Text ( ) Email ( )

Cancellation Policy

****In fairness to our other patients and to us, 24 hour notice is required for cancellation of an appointment, or you will be charged in full for the time booked. ****

( ) Cash Patient: I agree to keep my account current by paying at the time of services rendered.

( ) Insurance Patient: I agree to keep my account current and have provided authentic and current coverage information and consent to the billing practices of this office.

( ) PIP / LNI Patient: I agree to keep my account current and have provided authentic and current coverage and authorization information and consent to the billing practices of this office.

****Please let us know if at ANY time you have an open PIP or LNI claim****

Private Insurance Patients

For private insurance billing, please complete the insurance verification form and provide the following information:

Primary Insurance Company::______________________________Phone #:________________

Address:_______________________________City:____________State:__Zip:__________

Policy/ID/Member #:________________________Group/Plan #:________________________

Plan/Program Name:_______________________Name of Insured:_______________________

Insured's Address:____________________________City:_____________State:__Zip:_____

Insured's Phone:___________________Insured's SS#:________________Insured's DOB:______

Insured's Gender:______Insured's Employer:________________Your Relationship to Insured:_________ _Secondary

Insurance Coverage Information:____

PIP Patients:

Please Provide the Following Information IN ADDITION TO the Private Insurance Information:

PIP/Auto Accident Claim #:____________________PIP Insurance Co:_____________________

Date of Accident:_________Claims Adjuster:___________________Phone #:______________

Address for Claims:___________________________City:___________State:__Zip:______

LNI Patients:

Please Provide the Following Information IN ADDITION TO Private Insurance Info:

LNI Claim Number:________________________Employer:___________________________

Date of Injury:__________Claims Adjuster:___________________Phone #:_______________

Is your LNI Claim Department of Labor and Industries or a Self-Insured Claim?_____________________

Billing Address (Self-Insured Claims Only):Attn:____

______Address:________________________City:______________State:__Zip:_________

Status of Claim (Check One): ( ) OPEN ( ) PENDING ( ) DENIED ( ) CLOSED

Please Carefully Read the Agreements and Sign Below

- I personally accept full financial responsibility for all services rendered to me. I understand that I am financially responsible if my insurance does not cover services rendered, or if I do not provide 24 hours notice when canceling or changing appointments.
- I agree to pay all balances within 30 days of receiving an itemized statement.
- I hereby authorize my insurance company to send payments directly to Rain Delvin, EAMP, MAOM, LMP for services rendered to me.
- I agree to notify the office of Rain Delvin, EAMP, MAOM, LMP in writing if there is any change regarding my coverage or contact information.
- I hereby authorize the release of any medical other information acquired concerning my condition or other disabilities, both to and from Rain Delvin, EAMP, MAOM, LMP which will assist in the payment of any claim on my account.
- I recognize that certain, necessary procedures including Cupping, Moxa, Gua Sha, Herbal and Nutritional Guidance may not be covered by my insurance I hereby agree to pay for those services rendered but not covered by my plan.
- I have received and understand the policies and procedures of this office, including HIPAA Privacy Practices and financial obligations to receiving care. ***We may send you emails or texts regarding your appointments. Please check the following box if you do not wish to receive email or text regarding appointment scheduling.*** **( )**

By signing below, I hereby agree to all of the above agreements, and I request and contract to pay for the services of Rain Delvin, EAMP, MAOM, LMP:

Patient/Guarantor Signature:____________________________Date:__________

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