Vitalia Holistic Health Centre: Dr. JoAnna Forwell
Patient and Insurance Information Form

Please take a moment to complete this form in its entirety, ***including contacting your insurance company to fill out the PLAN/COVERAGE DETAILS section***, and sign at the bottom. This will enable smooth insurance billing and reimbursement for our office – and help your doctor make decisions about care and referrals. ~Thank you!

Patient Information

Name:	Date of Birth:	Today's Date:
Address:	Phone (mobile):	
(zip)	Phone (home):	
Employer:	Phone (work):	
Occupation:	☐ Single ☐ Married ☐ Partnered ☐ Other	
Email:		
Emergency Contact: (name, number, relationship)		
Who may we thank for referring you?		

Primary or Medical Insurance

Plan Name:	ID # (include alpha prefix):
Plan Address (back of card):	SS# (if different from ID#):
	Group #:
	Plan Phone# (back of card):

Plan / Coverage Details

Co Pay: $		Co-insurance percentage: _____ % up to a maximum of _____			
Annual Deductible: $_____ amount remaining $_____		Is Dr. JoAnna Forwell in-network or out-of-network?	☐ In-network	☐ Out-of-network	
Yearly Max for Prevention visits: $_____ # of visits:_____		Laboratory Services: In-network: deductible $_____ Coinsurance _____% Out of network: deductible $_____ Coinsurance _____%			
Coverage Limits	**$ Amount**	**# of visits**	**Referral or Prescription needed?**		
Naturopathic	$	#	☐ Yes	☐ No	☐ Self Ref. OK
Physical Medicine	$	#	☐ Yes	☐ No	☐ Self Ref. OK
Acupuncture	$	#	☐ Yes	☐ No	☐ Self Ref. OK
Massage	$	#	☐ Yes	☐ No	☐ Self Ref. OK
Chiropractic	$	#	☐ Yes	☐ No	☐ Self Ref. OK
Orthotic coverage? (please circle one) Yes / No Limits:					

Insured's Information, if other than self: (Please DO NOT skip this section!)

Name:				
Address:				
Date of Birth:				
Relationship to Insured:	☐ Self	☐ Child	☐ Spouse	☐ Other

PIP, L&I, or Secondary Insurance: Please notify us if your visit involves a motor vehicle accident or if you have secondary insurance.

Referring Physician's Name:_____ Phone:_____

I agree to the release of any medical information my health insurance company may need in order to process payment. I assign such benefits to be paid to JoAnna Forwell, ND. **I understand that Vitalia Holistic Health Centre submits insurance claims to eligible insurance plans as courtesy. I acknowledge that I am ultimately responsible for all fees incurred (for instance, if my insurance coverage expires or denies payment). I take full responsibility for knowing my insurance coverage and limits, and will work toward the goal of helping my practitioner receive reimbursement for her services.**

Signature _____ Date_____