

Vitalia Holistic Health Centre: Dr. Adam Geiger
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:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> 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. Adam Geiger in-network or <input type="checkbox"/> In-network <input type="checkbox"/> Out-of-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	\$	#	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Self Ref. OK
Physical Medicine	\$	#	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Self Ref. OK
Acupuncture	\$	#	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Self Ref. OK
Massage	\$	#	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Self Ref. OK
Chiropractic	\$	#	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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:	<input type="checkbox"/> Self	<input type="checkbox"/> Child	<input type="checkbox"/> Spouse	<input type="checkbox"/> 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 _____