



Finance/Insurance Form

| PLEASE PRINT AND COMPLETE ALL ENTRIES | | | | |
|---------------------------------------|---|----------------------------------|----------------|--------------|
| Patient Name (Last, First, MI) | Date of Birth | Age | Marital Status | Today's Date |
| Address (Street, City, Zip) | Home phone: | | | |
| | Work phone: | | | |
| | Cell phone: | | | |
| Social Security # | Who is financially responsible for this bill? | | | |
| Spouse/Parent Name (Last, First, MI) | Date of Birth | Home Phone. | Work phone | |
| Emergency contact | Relationship | Phone number | | |
| Email address: | | | | |
| INSURANCE | | | | |
| Primary Subscriber Name | Primary Subscriber SS# | Primary Subscriber Date of Birth | | |

Note: Medicare does **not cover Naturopathic services at this time.*

I agree to make payments according to the policies of Alpine Valley Wellness Center (AVWC), including all payments due at the time of visit. I agree to allow AVWC to charge my credit card or utilize my deposit if I fail to follow the cancelation policy for my first visit.

By accepting services at AVWC, I am agreeing to pay for that service even if my insurance company denies payment. I understand that the restrictions imposed by my insurance company are constantly changing and that the staff of AVWC are not responsible to track these changes. I understand that it is my responsibility to ensure that my insurance policy covers all treatments I am receiving. I agree to call my insurance company and verify benefits if I have any concerns. I understand that AVWC does collect co-payments at the time of my visit. I give permission for the release of information requested by my insurance company to assist in processing my insurance claims and assign directly to AVWC all appropriate payments from my insurance company for health care services rendered to me by AVWC.

Patient Name (Please Print)

Patient Signature

Date