Dr. Alice Holman, N.D., L.Ac.
Naturopathic Doctor and Acupuncturist
410 Bellevue Way SE, Suite 202, Bellevue, WA 98004 • Phone: 425-641-0555 Fax: 425-462-1802

CONFIDENTIAL PATIENT INFORMATION

Date ______________

Name____ Age______Birth Date ___________ Sex **M F**

Address_______________________________ APT# _______ City _________________ State___Zip________

Home Phone (____)___________ Work Phone (____)____________ Cell Phone (____)____________

Employer ___________________Occupation ___________________Student? **Y N** **Full** or **Part time**

SS# _____________________________ Driver's License #_____________________________________

Marital Status S M D W Number of Children _____Ages____________

Person to contact in case of emergency _______________________________ Phone # (____)_____________

How did you hear about our Clinic? (If phone book, please specify which one) _______________________

Email Address ___________________________ Would you like to receive information via email? Y N

INSURANCE INFORMATION

Dr. Holman is a provider for Premera Blue Cross, Uniform Medical, First Choice and Lifewise. Other plans may cover a percentage of the visit. Please call the number on the back of your insurance card to understand your plan's coverage. Thank you. For acupuncture treatments, Dr. Holman is not a preferred provider. Acupuncture packages are available.

Do you have medical insurance with Naturopathic Medical and Acupuncture Coverage? **Y N**

Insurance Company____________________________ Name of insurance plan _______________________

Name of subscriber ____________________ and date of birth __________ Relationship to patient_______

Subscribers address if different from patient ____

Subscriber SS#_________________Primary Care Physician________________Phone (____)____________

Would you like one of our Doctors to become your Primary Care Physician?________________________

Please call your insurance company (number on back of card) ask for the following information:

Do you need a referral before coming to our clinic? **Y N**

Is there a deductible? **Y N** (If yes) Individual $_______Family $_______ Amount paid to date $_______

Is there a Co-Pay? Y N $_______ What percent will your policy cover for treatment? ________________

PLEASE BRING YOUR CARD WITH YOU SO WE CAN MAKE A COPY FOR YOUR FILE

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and myself. I hereby authorize the undersigned physician the right to furnish medical information to my insurance carriers concerning this illness or accident. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable. Furthermore, any charges, fees, or court costs incurred as a result of collection efforts will be added to my account balance. Permission is hereby given for any medical treatment and any diagnostic procedures required for my health care, or (when patient is a minor child) for the health of my minor child.

______________________________ ________________________________ __________
Patient's Signature Parent or Guardian's Signature Date

CLINIC POLICY REQUIRES PAYMENT AT THE TIME OF SERVICE

We gladly accept: Cash • Check • Visa • MasterCard