# FIVE STONES Integrative Health

## PATIENT INFORMATION

First Name:_____MI:_____ Last Name:_____
Date of Birth:_____ Gender (circle one): Male Female
Street Address:_____ Apt or Unit #_____
City:_____ State: _____ Zip Code:_____
Telephone: (h)_____ (w)_____ (c)_____
email:_____
How long have you been living at this address?:_____
Employer:_____ Employer address:_____
(check one): ___Single ___Married ___Divorced ___Widowed ___Separated
If Patient is a minor, Custodial Parent:_____

## INSURANCE INFORMATION

**PRIMARY INSURED INFORMATION:**

First Name:_____MI:_____ Last Name:_____
Relationship to Patient: __Self __Spouse __Parent __Guardian
Date of Birth:_____ Gender (circle one): Male Female
Employer:_____ Employer Phone: _____
Insurance Company Name:_____
Policy #:_____ Group ID#:_____
Insurance Telephone:_____ Primary Physician:_____
Is injury work related? Yes No (circle one) Date of injury:_____ Claim#:_____
Auto accident related? Yes No (circle one) Date of accident:_____ Claim#:_____

## CONSENT AND RELEASE

I hereby authorize the payment of medical benefits to Vanina Wolf, L.Ac., Dipl.Ac, for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier. I permit a copy of this authorization to be used in place of the original. _____ (Initial)

I further agree to pay all collections costs, attorney fees, and other collections costs that may be incurred to enforce the collection of any amounts outstanding. _____(Initial)

I hereby authorize Vanina Wolf, L.Ac., Dipl.Ac., to release any medical information necessary to complete and process my insurance claims. _____(Initial)

X_____ Date:_____
(Signature of Patient or Custodial Parent if Patient is a minor)

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## Billing Policy & Acknowledgement of HIPAA Privacy Policy

The following sets forth the general billing policy of FIVE STONES Integrative Health, and of it's provider, Vanina Wolf, L.Ac. Dipl.Ac. Please review this information and sign where indicated.

☐ I understand that it is my responsibility to provide the office accurate billing information at the time of check in and to notify the provider of any changes in this information.
I understand that it is my responsibility to know my specialist co-pay (which can be different than my Primary Care co-payment) and to pay it prior to services being rendered. I understand that this is a contractual agreement that I have with my health plan and that the provider also has a contractual agreement with my health plan to collect co-pays at the time of service, and they are required to report to the carrier any enrollees failing to pay the co-pay.

☐ I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a $25 NSF fee. I further understand that to rectify my account, I will be required to pay with cash, a money order, cashier's check, or credit card.

☐ I understand that I will be billed for any amounts due by me (co-payments/coinsurance amounts/ deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with two (2) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the second statement being mailed, that the second statement will be marked as "Final Notice" and may be sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with the collection efforts.

☐ I understand that the provider will obtain the necessary prior authorizations prior to rendering treatment. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.

☐ I have received a copy of the Notice of Privacy Practices as required by HIPAA from FIVE STONES Integrative Health, and understand my rights with regard to my personal health information disclosure.

☐ I prefer to be contacted by email____, by text_____, or opt out of all communication _____ regarding my appointments. (circle one)

My signature below confirms that I have read and understand these billing policies, privacy practices and my financial obligation as pertains to the health care provider, Vanina Wolf, L.Ac., Dipl.Ac.

X_____ Date:_____

Patient's Signature