Acupuncture and Herb Clinic of Rhonda Feiman

Doctor of Asian Medicine

P.O.Box 233, Belfast, ME 04915 *Tel: 207-338-4454*

Name: Last_____First_____ MI____ Prefers to be called: _____

Home phone:_____ e-mail _____

Patient address:_____ City: _____

State: _____ Zip Code:_____ Work phone: _____Cell phone:_____

Fax: _____ Other: _____

Date of birth:_____ M___ F___ Minor__ Single__ Married__ Divorced__ Widowed__

Employer:_____

In case of emergency contact _____ Relationship to Patient_____

Emergency phone # _____

RESPONSIBLE PARTY

Name of person responsible for this account _____Relationship to patient_____

Address_____Phone_____

PRIMARY INSURANCE INFORMATION

Name of insured_____ Relationship to patient_____

Date of birth_____ Insurance company_____

Policy #_____ Group# _____

Do you have any additional insurance Yes___ No ___ If yes complete the following:

Name of insured_____ Relationship to patient_____

Date of birth _____Insurance company_____

Policy # _____ Group # _____

I authorize the release of any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/ or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient or guardian signature: _____Date: _____