Insurance Q&A

In order to help you navigate the sometimes confusing and frustrating world of insurance reimbursement, we ask you to please **fill out this form entirely before your first appointment** to ensure that your session will be covered by your insurance plan.

Primary Insurance Policy #:_____
Group #_____
Policy Holder, Full Name: _____
Patient Full Name:_____
Policy Holder DOB:_____ (mm/dd/yyyy)
Patient DOB:_____(mm/dd/yyyy)

Policy Holder Address: Patient Address:

_____ _____
_____ _____

Policy Holder Phone #:_____ Patient Phone#:_____

Your Relationship to Patient: XSelf XSpouse XParent XOther

- Policy Holder's Place of Employment: _____

- Policy Holder's Name of University/College (if insurance issued here):_____

Do You Have Secondary Insurance?

Secondary Insurance & Policy #_____Group #_____
Policy Holder, Name: _____
DOB (mm/dd/yyyy):_____
Policy Holder, Address:_____ Your Relationship to Client: XSelf XSpouse XParent XOther

NUTRITION Rx

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