

Authorization to Bill Third-Party Payer

SECTION 1: Patient Information

Last Name _____ First Name _____ Middle Initial _____
Date of Birth ____/____/____ SS# _____ Daytime Phone (____) _____

SECTION 2: Benefits and Billing Information

☞ Please notify the front desk staff if your visit is related to an injury or accident ☞

I. Does your insurance have alternative medicine benefits? Yes No

Who is your Primary Care Provider? Dr. _____ Clinic Phone (____) _____

Clinic Address _____ City _____ State _____ Zip Code _____

Does your plan require you to have a referral from you Primary Care Provider to receive coverage? Yes* No

*If yes, which licensed provider were you referred to at our clinic? _____

II. Primary Insurance Company & Plan Name _____

ID # _____ Group/Policy # _____

Name of Policy Holder _____ Policy Holder's Date of Birth ____/____/____

Policy Holder's Address _____ or (check if same as patient)

The policy holder is my _____ (specify relationship) Policy Holder's Gender (circle) Male Female

Is your Primary Insurance Policy a (circle) POS PPO EPO HMO Don't Know Other (specify) _____

III. Secondary Insurance Company & Plan Name _____

ID # _____ Group/Policy # _____

Name of Policy Holder _____ Policy Holder's Date of Birth ____/____/____

Policy Holder's Address _____ or (check if same as patient)

The policy holder is my _____ (specify relationship) Policy Holder's Gender (circle) Male Female

Is your Primary Insurance Policy a (circle) POS PPO EPO HMO Don't Know Other (specify) _____

SECTION 3: Guarantor Information

This section must be completed if someone other than the patient is financially responsible for the patient's account.

Last Name _____ First Name _____ Middle Initial _____

Date of Birth (required) ____/____/____ SS# _____ Gender (circle) Male Female

Address _____ City _____ State _____ Zip _____ Phone (____) _____

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient and that I am subject to all financial terms listed below.

X _____
Guarantor's Signature Date

I understand that all co-pays are due at the time of service and that I am financially responsible for all charges whether or not they are paid by my insurance. I understand that finance charges will begin accruing on accounts that are 60 days past due for payment at a rate of 1.5% per month. I further understand that excessively overdue accounts will be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that some third-party payers may require that my medical information, including copies of treatment notes, be submitted along with requests for payment. I hereby authorize Bastyr Center for Natural Health to release all medical information necessary to secure payment of benefits from the third-party payers specified above, and I authorize the use of this signature on all related submissions. I understand that this information may include medical information related to drug and alcohol abuse, sexually transmitted diseases, HIV/AIDS and mental health. I understand that this authorization shall remain valid without expiration unless expressly revoked by me in writing.

X _____
Patient's Signature Date

X _____
Guardian/Representative's Signature Date

Relationship to Patient/Representative Authority _____