Motor Vehicle Accident
Patient Insurance Information Form

Healing Spirit Touch, Inc
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Patient's Name: _____
(As Shown On Insurance Card) Last Name First Name Middle Initial

Gender: _____ Driver's License # And State: _____

Date of Birth: _____ Marital Status: Single ____ Married ____ Other _____

Patient's Address: _____

City: _____ ST: _____ Zip Code: _____

Contact Phone: _____ Best Time to Contact: _____

Emergency Contact: _____ Phone: _____

Patient's Employer: _____ Phone: _____

Patient Signature: _____

Parent/Legal Guardian signature if patient is a Minor:_____

Insured's Information if different from the Patient

Insured Or Guarantor's Name: _____

Insured's Birth Date: _____

Did Accident Occur While Driving A Company Vehicle? Yes No

Insured's Employer: _____ Employer's Telephone: _____

INSURANCE PLAN AND RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM ABOVE)

Insured's Claim Number: _____ Policy #**:** _____

Insurance Company Name: _____

Insurance Company Billing Address: _____

Phone: _____ Fax: _____Claim Representative: _____

Date Of Accident:	State Accident Occurred In:

Name Of Referring Physician:_____

Physician's Office Address:_____

Physician's Phone Number:_____

PLEASE REVIEW THE INFORMATION YOU HAVE PROVIDED TO ENSURE THE CORRECT DATA FOR YOUR CHART AND BILLING INFORMATION. PATIENTS ARE RESPONSIBLE FOR KEEPING THIS DATA UPDATED WITH EACH VISIT TO ENSURE TIMELY BILLING AND COLLECTIONS.

Insurance is considered a method of reimbursing the PATIENT for fees paid to the practitioner and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not covered or reimbursed by your insurance carrier.

By signing this information form, I have been informed that it is my responsibility to contact my insurance carrier to verify that any and all authorizations have been obtained prior to this visit. I understand that I am responsible for payment in full for all services rendered regardless of insurance. If this account is assigned to an attorney for collection and/or suit, the practice shall be entitled to attorney fees and costs of collection.

Initials: _____

Authorization of insurance benefits: I authorize insurance payments to go directly to Healing Spirit Touch, Inc. If payments are defaulted to me, I agree to pay Healing Spirit Touch, Inc. for all medical services provided. I authorize the release of any information necessary to determine liability for and to obtain reimbursement of any claim. This assignment shall remain in effect until revoked in writing by me. A photocopy of this assignment is to be considered as valid as the original.

Initials: _____

INSURED'S SIGNATURE: _____DATE_____

Healing Spirit Touch, Inc. 10151 SW Barbur Blvd. Suite 200D, Portland, OR 97219 503-245-0454
will be submitting the claim for services rendered to your insurance carrier. We encourage you to contact Healing Spirit Touch, Inc. if you have any questions or need further assistance.