

**Patient Information**

Name \_\_\_\_\_  
 Address \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_  
 Cell Phone \_\_\_\_\_ Email \_\_\_\_\_  
 I prefer to be contacted and messages left at my: Home Cell Work  
 Do you prefer to be called by a nick name? If so please list: \_\_\_\_\_  
 Marital Status: Single Married LTR Divorced Widowed Other \_\_\_\_\_  
 Occupation & Employer: \_\_\_\_\_  
 Parent or Guardian, if Patient is a minor child \_\_\_\_\_  
 Referred By: \_\_\_\_\_

**Insurance Information**

*We are members of Anthem, Sloans Lake, and Great West insurance networks.*

*We may also bill United Health, Secure Horizons, Aetna, and others on your behalf, however, we are not in-network for these carriers. Coverage for any carrier is policy dependent, may be subject to co-pays and deductibles, and is not guaranteed.*

Name of Insured \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_ ID # \_\_\_\_\_  
 Employer \_\_\_\_\_ Group # \_\_\_\_\_  
 Insurance Company \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Telephone \_\_\_\_\_ Injury? Y N Date Injured \_\_\_\_\_  
 Claim # \_\_\_\_\_ Auto Accident? Y N Work Related? Y N

**Primary Reasons for Visit** *Briefly comment on current condition or complaint*

\_\_\_\_\_

**Authorizations & Signature**

- I hereby authorize Acu-Choice to furnish information concerning my condition, complaint, or illness to my insurance company and direct the insurer to pay, without equivocation, to Acu-Choice Health Care any and all benefits and claims due them as a result of services provided.
- I understand that I am personally responsible for charges and balances not covered by my insurance, and agree to pay promptly any and all amounts due.
- I have received a copy of the Acu-Choice Healthcare Notice of Privacy Practices.
- I hereby state and agree that a photocopy of this document will be as valid as the original.
- I hereby authorize Acu Choice Health Care to release information to the following persons or family members regarding my care and any insurance issues.**

1. \_\_\_\_\_  
 Name Relationship to patient

2. \_\_\_\_\_  
 Name Relationship to patient

Acu- Choice Health Care has my permission to call my home YES NO

Acu-Choice Health Care May leave a detailed message at my home YES NO

- My signature below indicates that I understand if I choose to communicate with Acu-Choice Health Care using
- The means of e-mail that the information exchanged during the course of that e-mail may not be secure information.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_