Beacon Integrative Medical Center

Patient Name (last):_____ (first):_____(MI):____ DOB:*M*_____*D*_____*Yr*_____
What name would you like to be called? _____ Sex: ____ Male ____ Female
Street Address: _____ City,State,Zip _____
Mailing Address: _____ City,State,Zip _____
If you would like us to bill your insurance please provide your social security number: _____-_____-_____
***Please ask the front office if you have questions on what services can be billed to insurance, LSA scans cannot. ***
Email: _____
Cell phone: _____ Home phone: _____ Work Phone: _____
Preferred Method of Contact: Call _____ Text _____ Email _____
Marital Status: _____ Never Married _____Married _____Divorced _____Separated
Ethnicity: _____Hispanic or Latino _____Not Hispanic or Latino **_____Declined**
Race: _____American Indian/Alaska Native _____Asian _____Black/African American
_____White _____Native Hawaiian/Pacific Islander **_____Declined**

Emergency Contact: _____ Relationship: _____ Phone: _____
Mailing Address: _____ City, State, Zip _____

Self-Pay (Payment due at checkout)**:** _____
Please Bill My Insurance (Copayment due at checkout)**:_____**
I Provided my Insurance Cards to be Copied: _____

Insurance Policy Holder Information: ***Check if information is same as patient:*** **_____**

Name (last):_____ (first):_____(MI):____ DOB:*M*_____*D*_____*Yr*_____
What name would you like to be called? _____ Sex: ____ Male ____ Female
Mailing Address: _____ City,State,Zip _____
Social Security Number: _____-_____-_____ Email: _____
Cell phone: _____ Home phone: _____ Work Phone: _____

Financial Responsibility

I have requested services from Beacon Integrative Medical Center on behalf of myself and/or my dependents, and understand that by making this request, I am financially responsible for all charges incurred in the course of treatment. I further understand that fees are due on the date of service and I agree to pay all charges. Any account not paid in full within 90 days may be assessed fees and interest up to 12%.

Authorization to Release Information and Assignment of Insurance Benefits

I hereby authorize Beacon Integrative Medical Center to release any relevant information generated in the course of examination or treatment that is necessary to process insurance claims to insurance carriers.
I hereby assign all insurance benefits to which I am entitled for medical services provided to myself and/or my dependents by Beacon Integrative Medical Center to be issued directly to Beacon Integrative Medical Center. I understand that I am responsible for any amount not covered by insurance.

HIPPA-Privacy Policy

I have been offered a copy of Beacon Integrative Medical Centers privacy policy and have been given the right to read it in full before signing this form.

_____ _____
Patient/Responsible Party Signature Date