NATURAL HEALING FAMILY MEDICINE

LORI WIESER N.D.
NATUROPATHIC PHYSICIAN

Patient Information

Last Name: _____First Name_____Date:_____

Address:_____Email_____

City: _____State_____Zip_____

Telephone (Home):_____Telephone (Work):_____

Age: _____Date of Birth:_____Gender:_____SSN:_____

Married: _____Separated:_____Divorced:_____Widowed:_____Single:_____Partnership:_____

Employment: Employed____F/T Student_____P/T Student_____Retired_____Other_____

Employer:_____Work ph:_____

Employer address:_____

Primary Insurance Information

Does your insurance have alternative medicine benefits? (Y)___(N)____ Is your primary Medicare? (Y)__(N)__

Insurance Company Name:_____Phone:_____

ID # as shown on card:_____Group#:_____

Claims Address:_____City/St/Zip:_____

Policy holder's name:_____Date of birth:_____SSN:_____

Policy holder's address:_____City/St/Zip:_____

Relationship to you:_____(self)_____(spouse)_____(dependant)_____(other)_____

Employer of Insured:_____Phone:_____

Who is your Primary Care Provider? _____ Clinic Phone: _(_____)_____

Clinic Address: _____City:_____State:_____Zip Code:_____

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

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

Location 1: 411 N. 3rd St. Ste. A2 Elma, WA 98541 Phone: 360-402-4943

&

Trinity Massage and Wellness

Location 2: 3700 Martin Way E. #108 Olympia, WA 98506 Phone: 360-561-0171

NATURAL HEALING FAMILY MEDICINE
LORI WIESER N.D.
NATUROPATHIC PHYSICIAN

Secondary Insurance or L&I Information

Is this visit Injury related(Y)__(N)__ work related? (Y)__(N)__

Insurance Company Name:_____Phone:_____

Claims Address:_____City/St/Zip:_____

Subscriber's name:_____Date of birth:_____SSN:_____

Subscriber's address:_____City/St/Zip:_____

Relationship to you:_____(self)_____(spouse)_____(dependant)_____(other)_____

ID # as shown on card:_____Group#:_____

Employer of Insured:_____Phone:_____

I understand I am financially responsible for all charges and agree to pay for services. I understand that if I fail to provide complete and accurate billing information at the time of service I may be billed and held responsible for all charges. I understand if I cancel an appointment at least 24 hours in advanced I may be assessed a fee. I authorize the doctor to release to my insurance company(ies) any and all information necessary to process my claim. I further authorize that payments be made directly to the physician.

Signature_____Date:_____