Valley Holistic Healing Stillwater, MN 55082

Billing/Insurance Information Sheet

Client Name: _____ _____ _____
Last First MI

DOB: _____/_____/_____ M/F: _____ Single/Married/Other: _____ Employed/Student: FT/PT

Client's Address: _____ Home Ph. #: _____

_____ Alternative #: _____

If different:

Policy Holder's Name: _____ _____ _____
Last First MI

Policy Holder's DOB: _____/_____/_____ Self/Spouse/Child/Other: _____

Ins. Co. Name: _____ PAYOR ID: _____

Address/City: _____ ZIP: _____

Policy ID #: _____ Group ID#: _____

Co-Pay: _____ Deductible: _____ Prior Auth #: _____

Auto: Claim #: _____ Claim Adjuster's Name: _____

Phone #: _____ Date of Loss: _____

Fax #: _____ State of Accident: _____

Referring Physician/Chiropractor/Physical Therapist: _____

Date of Current: _____ DX: _____ DX: _____ DX: _____ DX: _____

Sessions Approved: _____ Billing Code: _____ Date: _____

Sessions Approved: _____ Billing Code: _____ Date: _____

Sessions Approved: _____ Billing Code: _____ Date: _____

By signing this form, you are authorizing the release of any medical or other information necessary to process claims with your insurance company listed above. You are also requesting payment of medical benefits to Valley Holistic Healing LLC and authorizing payment of medical benefits to Valley Holistic Healing LLC for the services received. You also understand that you will be responsible for the co-pay cost per visit, your deductible amount, and/or other charges based on your insurance coverage/plan, which may include full payment of services if your plan does not cover the services you have received.

Client Signature: _____ Date: _____