Nourishing Wellness Medical Center

Allen Peters, M.D
Jeanne Peters, R.D.

Date_________________________

Patient Information

Patient Name (Last - First - Middle) Mr. Dr. Ms. Mrs.	Gender M F	Date of Birth	Social Security No.
Address (street - City - State - Zip)	Cell Phone No. ( )		Home Phone No. ( )
City, State, Zip	Email		Fax No. ( )

In Case of Emergency, Notify	Emergency Contact's Phone No. ( )
Family Physician	Physician's Phone No. ( )
Whom May We Thank For Referring You To Us?	Phone No. ( )

Insurance Information

We cannot guarantee insurance coverage by your insurance carrier. The information below will assist us in determining if some of the expenses are reimbursable by your HMO or insurance carrier. **Please give your insurance card to our receptionist to be copied.**

Primary Insurance Carrier	ID #	Group #	Social Security No.
Name of Insured	Relationship to Insured	Date of Birth	Gender M F
Address (street - City - State - Zip)	Home Phone No. ( )	Work Phone No. ( )	
City, State, Zip	Employer	Occupation	

Secondary Insurance Carrier (if applicable)	ID #	Group #	Social Security No.
Name of Insured	Relationship to Insured	Date of Birth	Gender M F
Address (street - City - State - Zip)	Home Phone No. ( )	Work Phone No. ( )	
City, State, Zip	Employer	Occupation	

Initial	Authorization and Release
	I certify the above information is true and correct to the best of my knowledge. I certify that I (or my dependent) have insurance coverage and assign directly to Nourishing Wellness, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand and agree that I am ultimately responsible for payment – and that at this time services rendered ***may not*** be covered by my insurance. I understand that I am financially responsible for all charges whether or not paid by insurance.
	I authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that billing is done by a third-party and that I may contact them with questions regarding my account.

_______________________________ Patient / Responsible Party Signature

_______________________________ Relationship

_______________ Date