North Scottsdale Acupuncture
10250 N 92nd Street, Suite 301
Scottsdale, AZ 85258

Patient Name: _____ Patient DOB: _____

CONTACT INFORMATION:

Please indicate by circling where we may contact you:

Home yes / no Telephone # _____ Messages may be left: yes / no

Work yes / no Telephone # _____ Messages may be left: yes / no

Cell phone yes / no Telephone # _____ Messages may be left: yes / no

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT:

I acknowledge that I have received, reviewed and understand the Notice of Privacy Practices. These can always be reviewed again online at NorthScottsdaleAcupuncture.com under Resources.

Signature: _____ **Date:** _____/_____/_____

INSURANCE BILLING AUTHORIZATION:

I authorize and direct that my insurance benefits be paid directly to North Scottsdale Acupuncture. I realize that I am responsible to pay for any non-covered services. I hereby authorize the release of pertinent medical information to insurance carriers for the purposes of payment for services I receive from North Scottsdale Acupuncture.

Signature: _____**Date:** _____/_____/_____

PRIMARY INSURANCE:

Insurance Company: _____

Name of insured: _____ Insured's date of birth**:** _____/_____/_____

Address of Insured (If different from patient)

_____

_____

_____

Name of employer:_____

Insured ID: _____

Policy Group: _____

Group Name: _____

Relationship to Insured: _____