HOLISTIC HEALTH ASSOCIATES

603-B W. Patrick St Frederick MD 21701 301-620-1414

INSURANCE INTAKE FORM

Provider: Ryan Diener/ / Todd McCloskey /Priscilla Sullivan / Caitlin Toft / Ludwig Kragler / Frank Neely
Facility: Holistic Health Associates

Client Name:_____ Today's Date_____

Address:_____City_____ST_____Zip_____

Client Phone: (day)_____

DOB: _____Sex: M or F Marital Status: S M D W Full Time Student? Y or N

Employer: _____Full Time:___ Part Time:___ Position:_____

Primary Insurance: _____

Primary Insurance Holder's Name: _____ DOB: _____

Client's Relationship to Subscriber: _____

Insurance Phone Number (on card): _____

MemberID# _____Group # _____

Secondary Insurance:

_____

Secondary Insurance Holder's Name: _____ DOB: _____

Client's Relationship to Subscriber: _____

Insurance Phone Number: _____

MemberID# _____Group # _____

Please provide us with your insurance cards for claims filing.

My signature below authorizes:

1) **Provider to render treatment and apply for benefits.**
2) **Payment of medical benefits directly to the Provider.**
3) **The release of any medical or other information necessary to process this claim.**
4) **MEDICAL INSURANCE: We have contracts with Aetna, BC/BS Carefirst, Cigna, and United Healthcare companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason.**

Patient: _____Date:_____