Pacific Bay Integrative Health Center

Michael Vercos, M.S., L.Ac. Licensed Acupuncturist/Master Herbalist

PATIENT INFORMATION
PLEASE PRINT

Patient Name | Age | Birth Date | Cell Phone

Home Address | City / State / Zip

Phone | Email Address | Employer

Business Address | City / State / Zip

Occupation | Business Phone

Spouse/Partner's Name | Spouse/Partner's Employer

Business Address | City / State / Zip

Occupation | Business Phone

If patient is a minor, please give the name of his/her legal guardian.

How were your referred to our office? _____

We supply itemized statements for insurance purposes. Please let us know before you see your practitioner if you will need a statement.

Kindly notify us *at least* 48 hours in advance of any cancellation, or you will be charged for a full office visit.

I consent to treatment and to the appropriate use and disclosure of my confidential information for purposes of treatment and/or payment. I understand that total payment of the fees for services performed by MICHAEL VERCOS, L.Ac. is my responsibility and not that of the insurance company.

Signature of Patient or Legal Guardian Date

2901 Ocean Park Blvd., #126 Santa Monica, CA 90405 Phone 310.399.4043 Fax 310.399.4012

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I _____ hereby authorize _____

(Name of Insured) (Name of Insurance Company)

to pay and hereby assign directly to **PACIFIC BAY INTEGRATIVE HEALTH** all benefits, if any, otherwise payable to me for his services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to **PACIFIC BAY INTEGRATIVE HEALTH** will be credited to my account, in accordance with the above signed assignment.

_____ _____

(Authorized Signature of Subscriber) (Date)