MARLANE D. BASSETT, ND

PORTLAND, OR

(503) 235-2120

REGISTRATION INFORMATION

PERSONAL & WORK INFORMATION

Date: Patient Name:

Address: City: State: Zip:

Home Phone: Birthdate: / / ☐ M ☐ F Social Security # - - ☐ Single ☐ Married

Occupation: Employed By: Business Address:

City: State: Zip: Business Phone: Pager:

Mobile: Email:

How did you learn about our practice? ☐ friend ☐ ad ☐ yellow pages ☐ drive-by ☐ health professional ☐ other:

FINANCIAL & INSURANCE INFORMATION

Please choose one: ☐ I will pay my balance in full at time of service. ☐ I prefer to make payment arrangements prior to services being rendered.

Do you have Medical Insurance that covers Naturopathic ☐ Yes ☐ No

Insurance Co.: Address:

City: St. Zip: Phone: Adjuster:

Policy # Claim # Group or Plan or Program:

Insured Name: ☐ self ☐ other Insured Address:

Insured City: St. Zip: Insured Phone # Emergency #

Insured Social Security # - - Insured Birthdate: / / Insured Relationship to Patient: ☐ Spouse ☐ Child ☐ Partner

Insured Employer & Address:

Pre-Authorization Needed: ? Yes ? No Pre-Authorization #:

Insurance co-pay per visit: Deductible:

RECORDS RELEASE & ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the **Release of any Information** relating to claims for benefits submitted. I further agree and acknowledge that I authorize my physician to submit claims for benefits for services rendered, without obtaining my signature on each claim. I (patient) _____ hereby authorize (Insurance Co.)_____ to pay and hereby assign directly to _____ all owed benefits. I understand I am financially responsible for all charges incurred.

_____

Patient Signature or Guardian if patient is under 18 years of age Date