

Skyline Integrative Medicine, LLC

Dr. Jennifer Fletcher DC, LAc

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Phone: 503-222-5005 Fax: 503-222-1039

Patient Information

Last Name: _____ First Name: _____ M.I. _____

Home Address: _____ City: _____ State: _____ Zip: _____

Gender: M F SS#: _____ D.O.B _____ Home Phone: _____

Cell Phone: _____ Email: _____

Employer: _____ Work Phone: _____

Spouse or Guardian:

Last Name: _____ First Name: _____ M.I. _____

Home Address: _____ City: _____ State: _____ Zip: _____

SS#: _____ D.O.B _____ Home Phone: _____

Cell Phone: _____ Relationship to Patient: _____

Employer: _____ Work Phone: _____

Payment Method: Cash _____ Check _____ Credit Card _____ Insurance (Pre-approved) _____

Primary Insurance Co. _____ Primary Insured: _____

Policy #: _____ Group #: _____

Secondary Insurance Co. _____ Primary Insured: _____

Policy #: _____ Group# _____

Accident? Yes _____ No _____ If yes, please complete an accident questionnaire.

Workers Compensation: Yes _____ No _____ Please advise receptionist.

I, the undersigned, certify that (I or my dependents) have insurance as stated above and assign directly to the Skyline Integrative Medicine, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand insurance billing is done as a courtesy and I am responsible for contacting my insurance company to verify coverage and make sure all claims are processed according. If the insurance doesn't pay I am liable for any and all charges. In the event my account is placed with a collection agency I understand I will be liable for all court costs, attorney fees, interest due and collection costs. There will be a \$35.00 charge assessed for any missed appointment that is not cancelled 24 hours in advance of the appointment.