Skyline Integrative Medicine, LLC

Dr. Jennifer Fletcher DC, LAc
224 S Hamilton Street, Suite 101, Portland, OR 97239
Phone: 503-222-5005 Fax: 503-222-1039

Patient Information

Last Name: First Name: Initial:

Home Address: City: State: Zip:

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

Cell Phone: Email:

Employer: Work Phone:

Referred By:

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Spouse or Guardian:

Last Name: First Name: Initial:

Home Address: City: State: Zip:

SS#: D.O.B Hone Phone:

Cell Phone: Relationship to Patient:

Employer: Work Phone:

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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.

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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.

Responsible Party_____Date_____