DR. MICHELLE WALTER
NOBU Integrative Medicine
425.363.2970

Authorization to Bill Third-Party Payer

SECTION 1: Patient Information

Last Name: ____________________ First Name: ____________________ Middle Initial: ________
DOB: ________________ SS#: [redacted] Daytime Phone: (________)________________

SECTION 2: Benefits and Billing Information

I. Does your insurance have alternative medicine benefits? Yes No

Who is your Primary Care Provider?: Dr. ____________________ Clinic Phone #: (______)______________

Clinic Address: ____________________ City: ______________ State: ______ Zip Code: ___________

Does your plan require you to have a referral from you Primary Care Provider to receive coverage? Yes* No

*If yes, which licensed provider were you referred to at our clinic?: ____________________

II. Primary Insurance Company & Plan Name: ____________________

ID Number: ____________________ Group/Policy Number: ____________________

Name of Policy Holder: ____________________ Policy Holder's Date of Birth: ____________________

The policy holder is my: ____________________ (specify relationship) Policy Holder's Gender (circle): Male Female

Is your Primary Insurance Policy a (circle): POS PPO EPO HMO Don't Know Other (specify): _________

III. Secondary Insurance Company & Plan Name: ____________________

ID Number: ____________________ Group/Policy Number: ____________________

Name of Policy Holder: ____________________ Policy Holder's Date of Birth: ____________________

The policy holder is my: ____________________ (specify relationship) Policy Holder's Gender (circle): Male Female

Is your Secondary Insurance Policy a (circle): POS PPO EPO HMO Don't Know Other (specify): _________

SECTION 3: Guarantor Information

This section must be completed if someone other than the patient is financially responsible for the patient's account.

Last Name: ____________________ First Name: ____________________ Middle Initial: ________

Address: ____________________ City: ____________ State: ______ Zip: _________ Phone: (______)__________

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient and that I am subject to all financial terms listed below.

X ____ ____________________
Guarantor's Signature **Date**

I understand that all co-pays are due at the time of service and that I am financially responsible for all charges whether or not they are paid by my insurance. I understand that finance charges will begin accruing on accounts that are 60 days past due for payment at a rate of 1.5% per month. I further understand that excessively overdue accounts will be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that some third-party payers may require that my medical information, including copies of treatment notes, be submitted along with requests for payment. I hereby authorize NOBU Integrative Medicine to release all medical information necessary to secure payment of benefits from the third-party payers specified above, and I authorize the use of this signature on all related submissions. I understand that this information may include medical information related to drug and alcohol abuse, sexually transmitted diseases, HIV/AIDS and mental health. I understand that this authorization shall remain valid without expiration unless expressly revoked by me in writing.

X ____ ____________________
Patient's Signature Date

X ____ ____________________
Guardian/Representative's Signature Date

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