HALLOWITZ HOLISTIC HEALING, P.S.

TOBY HALLOWITZ, ND, MSOM, EAMP

**INSURANCE SUMMARY SHEET:**

PATIENT'S FULL NAME_______________________________________________MALE_________FEMALE__________

ADDRESS__________________________________________CITY____________________STATE______ZIP_____________

DATE OF BIRTH____________ SOCIAL SECURITY NUMBER ____________________ E-MAIL_______________________________

HOME PHONE #___________________________CELL #___________________________WORK #__________________________

SPOUSE NAME___________________________DOB___________________ PHONE #____________________________________

**RESPONSIBLE PARTY INFORMATION**

****PLEASE ASSIGN ONE SINGLE PERSON FOR ALL ACCOUNTS****

NAME___________________________________HOME PHONE #_________________________CELL #______________________

DATE OF BIRTH____________ SOCIAL SECURITY NUMBER ____________________ E-MAIL_______________________________

ADDRESS__________________________________________CITY____________________STATE______ZIP_____________

**EMERGENCY CONTACT**

****NEAREST CONTACT, NOT LIVING WITH YOU****

NAME____________________________________RELATIONSHIP TO PATIENT_______________PHONE #____________________

**PATIENT INSURANCE INFORMATION**

PRIMARY INSURANCE COMPANY_____________________________________________________________________

NAME OF POLICY HOLDER___________________________________DATE OF BIRTH______________SSN_________________

ID #________________________________________________________GROUP #_______________________________________

SECONDARY INSURANCE COMPANY__________________________________________________________________

NAME OF POLICY HOLDER___________________________________DATE OF BIRTH______________SSN_________________

ID #________________________________________________________GROUP #_______________________________________

All professional services rendered are charged to the patient, necessary forms will be completed to help expedite insurance carrier payments. However, the parent or legal guardian is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless prior arrangements have been made with the office bookkeeper. Should this account be referred to an attorney and/or third party for collection, the undersigned shall pay reasonable collection expenses.

I AUTHORIZE THIS OFFICE TO RELEASE TO MY INSURACNCE COMPANY, THIRD PARTY, MEDICAL FACILITY OR ATTORNEY ANY MEDICAL INFORMATION NECESSARY TO EXPEDITE MEDICAL CARE AND/OR INSURANCE PAYMENT.

**I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES, REGARDLESS OF INSURANCE COVERAGE**.

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO TOBY HALLOWITZ, ND. FOR SERVICES PROVIDED.

Financial Policy: In order to assure a positive-on-going relationship with our patients, we have documented the following policies that apply to billing and collection of all fees for services rendered by our practice. It is our sincere desire to offer the best possible service to you, our patient. You will be asked to sign this statement, just as the representative presenting it will be, so that the chance for misunderstandings is minimized. You are encouraged to contact our office if there is ever any concern about your account of the method of administration thereof.

- The responsibility for the payment of all account balances belongs to the individual identified as the guarantor. This is normally the patient except for minors or other dependents. There is no exception to this rule.
- Insurance will only be billed when the Patient Benefit Summary is submitted to the office and Toby Hallowitz, ND is listed as an in-network provider with the patient's plan. We bill the insurance as a courtesy and therefore, the guarantor is ultimately responsible for any unpaid or denied services.
- Patients/Guarantors are expected to promptly report to the office any changes in insurance coverage that directly affect the ability of the practice to get paid.
- **I UNDERSTAND THAT DR. TOBY HALLOWITZ'S OFFICE DOES NOT BILL MEDICARE OR MEDICAID.**

PATIENTS ARE THE MOST IMPORTANT CONSIDERATION IN OUR PRACTICE. These policies are designed and instituted in order to insure a consistent and predictable method of providing service to all of our patients.

By signing below, I acknowledge the policies stated above.