Unbroken Flow Acupuncture, LLC
Kendra A. Ward, L.Ac. MAOM
2920 SW Dolph Ct. Ste 2, Portland OR 97219
(503) 244-1494

PERSONAL & WORK INFORMATION

Patient Name: Date: Date of Injury/Accident:

Address: City: State: Zip:

Home Phone: Cell Phone: Work Phone:

Birthdate: / / ☐M ☐F Social Security # - - ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Email: Occupation: Employed By:

Business Address: City: State: Zip:

How did you learn about our practice? ☐friend ☐ad ☐internet ☐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 Acupuncture ☐Yes ☐No If yes, Please check the type of Insurance: ☐Private Insurance Company

☐Workman's Comp. (see other form) ☐Personal Injury (see other form) ☐Other:

Insurance Co.: Address:

City: St. Zip: Phone: Adjuster:

Policy # Claim # Group or Plan or Program:

Insured Name: ☐self ☐ (please fill in below) Insured Address:

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

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

Insured ☐M ☐F Insured Employer & Address:

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 authorize Kendra A. Ward. L.Ac. of Unbroken Flow Acupuncture, LLC 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 Kendra A. Ward. L.Ac, all owed benefits. I understand that I am financially responsible for all charges incurred, whether or not they are covered by my insurance company. This authorization shall remain valid until written notice is given by me revoking said authorization.

Signature of Patient_____ Date_____