

CALM SPIRIT ACUPUNCTURE
11890 West 64th Avenue, Arvada, CO 80004
(303) 467-5337

EMAIL _____
If you would like to receive select health related articles.

Patient Information

LAST NAME _____ FIRST _____ MI: _____

DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CELL PHONE _____ HOME PHONE _____

EMPLOYER _____ WORK PHONE _____

WORK ADDRESS _____

IN CASE OF EMERGENCY,
CONTACT _____ PHONE _____

RELATIONSHIP _____

PERSONAL PHYSICIAN _____ DATE OF LAST DR.'S VISIT _____

PHONE # _____

PLEASE READ THE FOLLOWING POLICY, AND SIGN:

I understand that I am responsible for the payment of all services rendered to me by Golden Acupuncture Inc. dba Calm Spirit Acupuncture. I understand payment is due at the time of service. In the event of non-payment by me within thirty (30) days from date of invoice, I agree that Golden Acupuncture Inc. dba Calm Spirit Acupuncture may assess interest at the rate of 1 1/2 % each month (18%/annum). I further agree to pay any costs, including reasonable attorney fees, incurred by Golden Acupuncture Inc. dba Calm Spirit Acupuncture in the collection of any unpaid balance due from me.

I agree to provide 24 hours cancellation notice, or I will be billed \$30.

I AGREE WITH THESE POLICIES: _____ **Date** _____

WITNESS _____ **Date** _____

Insurance Information Do you have a referral/prescription? _____

Name of insured: _____ Relationship to patient: _____

Employer of insured: _____ Insured's Date of Birth: _____

Insurance Company: _____ Phone Number: _____

Policy Number/Group # _____

IS THIS TREATMENT RELATED TO:
A WORK INJURY? _____ or AUTO INJURY? _____ or OTHER? _____ DATE OF ONSET _____

IF WORK OR AUTO, PLEASE PROVIDE: CLAIM # _____

ADJUSTOR NAME _____ PHONE # _____

FOR INSURANCE BILLING, PLEASE READ AND SIGN:

I authorize Golden Acupuncture Inc. dba Calm Spirit Acupuncture to release any medical information deemed necessary in the course of treatment. _____ **Date** _____
I authorize payment of medical benefits to be paid directly to Golden Acupuncture Inc. dba Calm Spirit Acupuncture. If my insurance does not pay I realize that I am responsible for paying any balance remaining.

Name _____ **Date** _____

Witness _____ **Date** _____