

CALM SPIRIT ACUPUNCTURE  
11890 West 64<sup>th</sup> Avenue, Arvada, CO 80004

(303) 467-5337

**Patient Information**

LAST NAME \_\_\_\_\_ FIRST \_\_\_\_\_ MI: \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

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 ½ % 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 \$60.

**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 # \_\_\_\_\_ Social Security # \_\_\_\_\_

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** \_\_\_\_\_