yinfinite WELLNESS

10 El Camino Real, Suite 202 • San Carlos, CA 94070
T: 650.596.5616 • F: 650.596.5653 • www.yinfinitewellness.com

# PATIENT IDENTIFICATION INFORMATION

Please Print

Patient Name _____ Patient I.D.#_____
Last First

Address_____

_____ _____ _____
City State Zip

D.O.B._____ Email_____

SS#_____ Marital Status_____

Phone (Home)_____(Work)_____(Cell)_____

## INSURANCE PAYMENT AND MEDICAL RELEASE AUTHORIZATION

I request that payment of authorized insurance benefits be made on my behalf to Brielle E. Kelly, L.Ac., Inc. for any equipment or services provided to me by said corporation. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the corporation or my insurance carrier or other medical entity. A copy of this authorization will be sent to my insurance company or other entity if requested. The original authorization will be kept on file by the said corporation. I understand that I am financially responsible to the corporation for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the corporation and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products and services received.

_____ _____
Patient Signature Date Print Name

## PRIVACY NOTICE

I have read (or have had read to me) and fully understand the Notice of Privacy Practices as required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The receptionist will provide the complete privacy notice upon my request.

_____ _____
Patient Signature Date Print Name

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