Full Circle Center
4641 Valley East Blvd., #2
Arcata, CA 95521-4630
707-840-4701
Fax 855-420-6321

New Patient Demographic and Insurance Information

Title: Patient Name: Gender:
Address:
City: State: Zip code:
Cell phone: Home Phone:
E-mail address:
I prefer to receive notification of confidential results via:
Marital Status: Employer:
Date of Birth: Social Security Number:
Preferred Language: Ethnicity and Race (Optional):

Responsible Party (Person financially responsible for this account, if other than patient):
Title: Name: Gender:
Address:
City: State: Zip code:
Cell phone: Home Phone:
E-mail address:
DOB: Social Security #:

Insurance information
Primary Insurance Carrier Name:
Insurance Address:
Insurance Phone Number:
Group Name: Group #:
Subscriber Name: Subscriber ID with Insurance Company:
Subscriber Gender: Subscriber DOB: Subscriber SSN:
Subscriber relationship to patient:

If the patient is covered by a secondary insurance policy, please complete the information below for coordination of benefits. This will enable the insurance company to process the claim more quickly.
Secondary Insurance Carrier Name:
Insurance Address:
Insurance Phone Number:
Group Name: Group #:
Subscriber Name: Subscriber ID with Insurance Company:
Subscriber Gender: Subscriber DOB: Subscriber SSN:
Subscriber relationship to patient:

If covered by Workers' Compensation or insurance related to an accident, please fill out the information below:

Person responsible for payment:
Date of Injury:
Industrial Claim #:
Name of Insurance Company or Program:
Address:
Policy number:
Were you injured on the job? ☐

I hereby give authorization for payment of insurance benefits to be made directly to my Healthcare Provider at the Full Circle Center for Integrative Medicine, and any assisting physicians, for services rendered. This authorization shall remain valid until written notice is given by me revoking such authorization.

I understand that I am fully responsible for all charges whether or not they are covered by insurance. A service charge of ½% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 30 days of treatment date. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees.

I understand that nutritional consultation and herbal consultation are not covered by insurance and that there will be a surcharge for these services.

I hereby authorize the release of any medical information needed to secure the payment of benefits. I further agree that a photocopy of this document shall be as valid as the original. I also authorize discussion of my case among the providers at Full Circle.

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Signature of Patient or Responsible Party Date