Brett VanCott, L.Ac.
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207-446-3103

Patient Intake Form

NAME_____________________________________DATE OF BIRTH____________________

ADDRESS________________________CITY__________STATE________ZIP___________

HOME PHONE_______________WORK ______________________CELL _______________

EMERGENCY CONTACT NAME/NUMBER______________________________________

REFERRING DOCTOR/ADDRESS/PHONE/FAX______________________________________

CONDITION RELATED TO:
WORK____________AUTO ACCIDENT__________ILLNESS________ OTHER________
DATE OF INJURY OR ONSET OF ILLNESS:________________

Billing Status Cash Insurance Auto Accident Work Comp Other

For Patients with Insurance:
Insurance Company____
Billing Address____
Phone Number____
Name of Insured_______________________________________DOB______________________
Relationship to you___________________Employer________________________________
Policy ID #__________________________________Group #________________________
Plan Name________________________________Referal/Authorization #__________________
Deductible________________How much has been met so far this year?____________________
Limit on $ amount or # of treatments per year?_________________________________
Case Manager______________________________Phone_____________________________

In the event that my Insurance Company does not cover the incurred expenses, I will be responsible for the payment in full. I understand that 24 hour notice is required to cancel or change an appointment, otherwise I will be charged for it and my insurance company will not pay this fee. I also understand that it is my responsibility to confirm that my insurance covers acupuncture.

Signature_______________________________________Date_________________________

Word/Brett Vancott/Insurance Forms