

Associated Health Care, LLC ~ Louise D. Gutowski, NMD
8149 North 87th Place, Scottsdale, AZ 85258

(PLEASE PRINT)

Legal Name: Last _____ First _____ MI _____

Address _____ Apartment # _____

City _____ State _____ Zip Code _____

Home Phone () _____ Pager/Cell Phone () _____

e-mail: _____

Date of Birth _____ Sex: M ___ or F ___ S.S. #: _____

Employer: _____ Work Phone () _____ Ext. _____

Marital Status: Single ___ Married ___ Divorced ___ Widowed ___

Spouse/Partner's Last Name _____ First Name _____ MI _____

Spouse/Partner's Date of Birth _____ S. S. # _____

Spouse/Partner's Employer _____ Work Phone () _____ Ext. _____

NEAREST LIVING RELATIVE ** (SOMEONE OTHER THAN YOUR SPOUSE/PARTNER) **

Name _____ Relationship to Patient _____

Home Phone () _____ Work Phone () _____ Ext. _____

Who Referred You To Our Office? _____

Who Is Your Primary Care Physician? _____

Were you in an automobile accident in the last 12 months? _____ If so, when? _____

With whom may we discuss your medical information (i.e. spouse, children, friend, other relative)? _____

****MOST INSURANCE COVERAGE PAYS ONLY A PORTION OF THE COST OF SERVICES**CHECK YOUR BENEFITS ****

Primary Insurance Company _____

Policy Holder's Name _____ Date of Birth: _____ S. S. # _____

Secondary Insurance Company _____

Policy Holder's Name _____ Date of Birth: _____ S. S. # _____

I understand I am responsible for ALL charges incurred regardless of possible insurance coverage, except as otherwise provided by contract or law. If my account is assigned to an attorney for collection and/or suit, the practice shall be entitled to reasonable attorney's fees and costs of collection. I hereby authorize Associated Health Care, LLC to file insurance on my behalf, where applicable, and to release any Protected Health Information necessary to process such claims. I hereby authorize my physician to file a lien with the County Recorder's Office documenting the existence of any outstanding charges owed by me to the physician. I hereby authorize payment directly to the physician of the medical benefits, if any, otherwise payable to me. I have read and completed all the information on this sheet and certify this information is true and correct to the best of my knowledge. I will notify the practice of any changes in my health insurance status or any changes in the above information. I am aware of the policies regarding payment and furthermore consent to treatment by Louise D. Gutowski, NMD (Associated Health Care, LLC).

Signature: _____ Date: _____

I, _____ have reviewed my medical benefits policy manual, that was provided to me by my insurance company. I understand the reimbursement benefits, which include the deductible, coinsurance percent of payment, and /or co-pay amount and non-covered services that I am responsible for to the doctor I am receiving services from.

Co-pays, co-insurance and deductibles are due when services are rendered. The remaining balance, if any, is due upon receipt once your insurance company has processed your claim. **CO-PAYS ARE DUE AT TIME OF SERVICE.**

PLEASE BE ADVISED THAT MEDICARE, BLUE CROSS BLUE SHIELD AND HMO PLANS DO NOT COVER ANY SERVICES PROVIDED BY A NATUROPATHIC PHYSICIAN.

If you have a “PPO” policy, please be advised that the doctor is **NOT** contracted with any “PPO” plans. What this means to you is you will be using your “Out of Network” benefits (if you have this benefit) so you will be subject to a higher out of pocket cost, which is normally a larger deductible and a higher co-insurance percent, if the charges are covered at all.

Patient Signature: _____ Date: _____

Legally Authorized
Representative & Relationship: _____ Date: _____
(If Patient Is Unable To Sign)

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The law requires that we provide to the patient a copy of our Notice of Privacy Practices for health information. By signing below, the patient acknowledges receipt of such, or if you are the patient’s legal representative or authorized agent, you acknowledge receipt of such.

Patient Signature: _____ Date: _____

Legally Authorized
Representative & Relationship: _____ Date: _____
(If Patient Is Unable To Sign)

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining acknowledgement
- Other (please specify) _____

Office Staff Signature: _____ Date: _____