DelVal Integrative Health Partners, LLC
Rebecca Nice, DO

205 Telford Pike
Telford, PA 18969

Phone: 215.383.1305
Fax: 215.383.1306

PATIENT INFORMATION

(Please Print) **(Circle one)**

Name_____ D.O.B._____ Sex M F Age_____

Address_____ SS#_____

(Circle one)

City_____ State ____ Zip_____ Marital Status S M W D

Home Phone (_____) _____Cell Phone (_____) _____

Email _____

Employer_____Work Phone (_____)_____

Spouse's Name_____ D.O.B_____

Spouse's Employer_____

Emergency Contact_____ Phone (_____) _____

(Name of Individual NOT Group Name)

***Referring Doctor_____**

Pharmacy_____Phone(_____)_____

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INSURANCE INFORMATION

(Please present insurance cards to receptionist) ID Checked_____

Primary Ins._____ Address_____

ID#_____ Group#_____ Subscribers Name_____

Subscribers Relationship to Patient _____Subscribers D.O.B._____

Secondary Ins._____ Address_____

ID#_____ Group#_____ Subscribers Name_____

Subscribers Relationship to Patient _____Subscribers D.O.B._____

Is patient a student? _____ Full time ___ Part time___

Race American Indian__ Asian__ African American __Caucasian __Other __

Ethnicity Non-Hispanic__ Hispanic __ Language English__ Spanish __ Other __

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ASSIGNMENT of BENEFITS/AUTHORIZATION to RELEASE INFORMATION

I request that payment of authorized private insurance benefits be made on my behalf to DelVal Integrative Health Partners, LLC, Rebecca Nice, DO, for any service furnished to me by my physician. This also applies to all secondary insurance. I authorize any holder of medical information about me be released to the private insurance company/ies which need any information in determining these benefits payable for related services.

Authorized Signature _____Date_____

Parent/Guardian_____Date_____

OFFICE POLICIES

I understand that patient co-pays are due at time of visit. An additional $10 service fee will be billed if co-pay is not paid at time of visit.

Authorized Signature _____Date_____

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WORKMANS COMPENSATION OR AUTO ACCIDENT

(If patient's condition is work related or auto accident, please fill in the following information)

Claim number for filing claim_____

Insurance Company _____

Insurance Address_____

Workplace Name (if W. Comp) _____

Work Address_____

Date of injury/accident_____