Inner Light, LLC
Carolyn Fuchs, LP

Date_______________

Dx:_______________

Patient Information

Patient Name (Print)_______________ **Date of Birth**_______________

Cell Phone:_______________

Street Address_______________ Home Phone_______________

Okay to Leave Message?____Yes____No

City_______________ **State**________ **ZIP**__________ Work Phone_______________

Okay to Leave Message?____Yes____No

Soc Sec#:_______________ Emergency Contact_______________ Emergency Phone_______________

Sex: ____M ____F Age_______ Marital Status: ____Single ____Married ____Widowed ____Divorced ____Partnered

Employer_______________ Occupation_______________ E-Mail:_______________

Referred by_______________ May we acknowledge this referral?_______________

Primary Insurance Company_______________ Phone_______________

Ins Claims Address_______________ **City**_______________ **State**______ **Zip**__________

Policy/ID_______________ **Group/Plan ID**_______________

Name of Policyholder_______________ **Relationship**_______________

Address_______________ City_______________ State________ Zip__________

Soc Sec #_______________ Employer_______________ **Policyholder's Date of Birth**_______________

Secondary Insurance Company_______________ Phone_______________

Ins Claims Address_______________ **City**_______________ **State**______ **Zip**__________

Policy/ID_______________ **Group/Plan ID**_______________

Name of Policyholder_______________ **Relationship**_______________

Address_______________ City_______________ State________ Zip__________

Soc Sec #_______________ Employer_______________ **Policyholder's Date of Birth**_______________

Responsible Party

Name_______________ **Relationship**_______________

Address_______________ **Phone**_______________

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the healthcare provider to release all necessary information to A.C.E. Billing, Inc, to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

_______________ _______________ _______________

Responsible Party Signature **Relationship** **Date**