

Integrative Health Specialists of Indiana
 9333 N. Meridian, Suite 202
 Indianapolis, IN 46260
 Phone # (317) 580-9333
 Fax # (317) 818-8933

Last	First	MI
Address		
City	State	Zip
Home #	Cell#	Work #
Employer	Employer Address	Marital status
/ /	- -	Referred by
Birthdate	Social Security #	Med Allergies

Primary Care Physician: _____ Telephone #: _____

Policyholder Information

Last	First	MI
Address		
City	State	Zip
Home #	Work #	
Birth date	Social Security #	Relationship to patient

Patient/Guardian Signature _____ Date _____

AUTHORIZATION TO PAY BENEFITS TO PROVIDER AND TO RELEASE INFORMATION

I request payment of benefits to be made to Integrative Health Specialists (IHS) for any services furnished to me by this group. I authorize any holder of medical information about me to release to the insurance carrier(s) and its agents any information needed to determine these benefits or the benefits payable for related services. I recognize that if my insurance carrier(s) requires a referral and/or authorization for any or all services rendered by IHS that I am responsible for obtaining the referral and/or authorization. In the absence of such referral and/or authorization, I may be held financially liable for the full amount of the charges for services rendered. I agree to pay IHS for any amounts not paid by my insurance carrier for medical services rendered. I am also responsible for any attorney fees required to collect for these services, court costs and collection agency fees.

NO-SHOW POLICY

There will be a \$25 fee for not canceling appointments at least 24 hours prior to scheduled times. _____
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