NORTHSHORE INTEGRATIVE HEALTHCARE

Phone and Fax: 847-920-4NIH (4644)
www.NorthshoreIntegrativeHealthcare.com

Demographic Form

Name: _____ Date: _____

Primary Phone: _____ DOB: _____

Secondary Phone: _____ Gender: Male Female
Circle One: Single Married Other

Address: _____ Email: _____

City, St., Zip: _____ SS#: _____

Primary Insurance Company

Insurance Company: _____ Insured Name: _____

Member ID#: _____ Insured DOB: _____

Group#: _____ Insurance Phone: _____

Secondary Insurance Company (If Applicable)

Secondary Insurance Company: _____ Insured Name: _____

Member ID#: _____ Insured DOB: _____

Group #: _____ Insurance Phone: _____

Assignment of Benefit Authorization

Your signature is necessary for us to process to your insurance carrier all claims and to ensure payment for services rendered.

I request that payment of authorized _____ (Name of Insurance Carrier) benefits be made to Northshore Integrative Healthcare for any services furnished by Northshore Integrative Healthcare. I authorize any holder of medical information about me to release _____ (Name of Insurance Carrier) and its agents any information needed to determine these benefits of the benefits payable for related services.

I agree to be financially responsible for all charges. I have read this information and understand.

_____ _____

Print Name Signature

If you have any questions, please call Echo Billing Solutions at 847-847-1792.