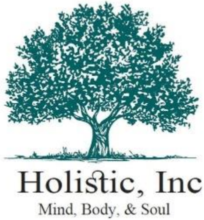

SHAWN BLANKENSHIP, FNP-BC

Patient Application / Intake Form

The purpose of this form is to make sure our practice is the right fit for you.

Legal Name: ____ Date of Birth: ____________________

Address:___________________________________ City:______________ State:______ Zip:___________

Home Phone:_________________________ Cell:_______________________ SS#______________________

Employer:_______________________________________ Business Phone:________________________

Occupation:____________________________________ Referred by:_____________________________

Emergency Contact / Relationship:______________________________ Phone:______________________

Insurance:_________________________________ ID _______________________ Group_____________

Secondary Insurance:________________________ ID _______________________ Group_____________

Insured First, Middle, Last Name __________________________________ DOB: ____________________

Insured Employer: ___________________________________ Business Phone ____________________

Relationship to Patient: ____

Insured Home Address: _______________________________ Phone Number: ______________________

RELEASE OF INFORMATION, BENEFIT ASSIGNMENTS, PAYMENT AUTHORIZATIONS, FULL DISCLOSURE STATEMENT, AND AGREEMENT TO PAY FOR PROFESSIONAL SERVICES.

I HEREBY AUTHORIZE HOLOSTIC, INC. (SHAWN BLANKENSHIP, FNP-BC) TO RELEASE MY INFORMATION NECESSARY TO PROCESS MY INSURANCE /MEDICARE CLAIM ACUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT: TO ALLOW A PHOTOCOPY OF MY SIGNATURE TO BE USED TO PROCESS MY INSURANCE/MEDICARE CLAIM FOR THE PERIOD OF A LIFETIME. I CLAIM ANY INSURANCE BENEFITS DUE TO ME FOR SERVICES RENDERED BY HOLISTIC, INC. AND AUTHORIZE AND DIRECT ANY CARRIER TO ISSUE PAYMENT CHECKS DIRECTLY TO HOLISTIC, INC. REGARDLESS OF MY INSURANCE BENEFITS, IF ANY. I UNDERSTAND THAT I AM FULLY FINANCIALLY RESPONSIBLE FOR ANY AND ALL FEES INCURRED, AND I AGREE TO PAY SUCH FEE IN FULL. THE INSURANCE INFORMATION FURNISHED HERE REPRESENTS A FULL DISCLOSURE OF THE INSURANCE/THIRD PARTY BENEFITS TO WHICH I AM ENTITLED. I UNDERSTANF THAT FAILURE TO DISCLOSE PRE-CERTIFICATION /SECOND OPTION REQUIREMENTS FOR ANY AND ALL PLANS TO WHICH I SUBSCRIBE MAY CAUSE ME TO INCUR FULL LIABILITY FOR PROFESSIONAL CHARGES, AS A RESULT OF NON-PAYMENT BY ANY CARRIER.

Patient/ Responsible Party Signature: _________________________________ Date: _________________

Living Will/ Advance Directives: YES NO