PRIMAVITA
FAMILY MEDICINE

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MEDICAL INSURANCE INFORMATION

Name: _____ Sex: M / F

Date of Birth (DOB): _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

E-mail address: _____ ❒ I do not have Medical Insurance

PRIMARY INSURANCE INFORMATION

Insured Subscriber's Name: ❒ Self ❒ (*please print full name*) _____

DOB of Insured Subscriber (*if not yourself*): _____

Relation to Insured Subscriber: ❒ Not Applicable ❒ _____

Insurance Company: _____ Insurance Phone Number: _____

Group #: _____ ID #: _____

SECONDARY INSURANCE INFORMATION (*if applicable*)

Insured Subscriber's Name: ❒ Self ❒ (*please print full name*) _____

DOB of Insured Subscriber (*if not yourself*): _____

Relation to Insured Subscriber: ❒ Not Applicable ❒ _____

Insurance Company: _____ Insurance Phone Number: _____

Group #: _____ ID #: _____

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was created by the U.S. Congress to increase the privacy of individuals' personal health information. It affects all those who are in contact with medical records or personal health information. For a detailed copy of our HIPAA practices please see "Notice of Privacy Practices".

(*please initial*)_____ I have received a copy of the "Notice of Privacy Practices"
(*please initial*)_____ I understand that if I make an appointment and do not cancel the First Appointment within 48 hours or Returning Appointment 24 hours in advance, I will be charged for that missed appointment.

I, the undersigned certify that I (or my dependent) have insurance coverage as written above, and assign directly to Dr. Lorina Shinsato all insurance benefits, if any, otherwise payable to me for services rendered. I authorize therapy necessary for treatment and agree to pay all fees and charges for such treatment if coverage is not available. I also authorize the release of any medical or other information necessary to process insurance claims related to treatment to Dr. Lorina Shinsato's medical billing company.

_____ _____
Signature of Patient or Guardian Date