Insurance & Billing Information – Michael Aanavi, PhD, LAc / Depth Therapies Alaska, LLC

Name:_____ Date:_____
Date of birth:_____ Gender: M_____ F_____ Soc Sec #:_____
Address:_____
City_____ State_____ Zip:_____
Home phone:_____ Work #:_____ Cell #:_____
Email:_____

Medical insurance company:_____
If covered through employer/group, name of employer/group:_____
Insurance ID#:_____ Plan name:_____
Group #:_____ Group name:_____

If policy holder is other than patient, name:_____
Relationship to patient:_____ Date of birth:_____ Gender: M____ F____
Address (if different than patient):_____
City_____ State_____ Zip:_____
Home phone:_____ Work #:_____ Cell #:_____
Email:_____

May we contact this person if we have questions about this insurance? Y____ N____

Secondary insurance company:_____
If covered through employer/group, name of employer/group:_____
Insurance ID#:_____ Plan name:_____
Group #:_____ Group name:_____

If secondary policy holder is other than patient, name:_____
Relationship to patient:_____ Date of birth:_____ Gender: M____ F____
Address (if different than patient):_____
City_____ State_____ Zip:_____
Home phone:_____ Work #:_____ Cell #:_____
Email:_____

May we contact this person if we have questions about this insurance? Y____ N____

By signing below:

- I authorize the release of any medical or other information necessary to process my insurance claims.
- I authorize payment of my government and/or private insurance benefits directly to Dr. Michael Aanavi.
- I understand that Dr. Aanavi offers insurance billing as a courtesy; I assume responsibility for all charges, and agree to pay any denied claims, non-covered charges, deductibles and copayments, and any fees excessively delayed or otherwise not reimbursed by my insurance carrier for any reason.

****Please bring all insurance cards along with this form to your first appointment.****

_____ _____
Signature Date