Nikol Angel, LAc.
at Laughing Mountain
Invigorating Vitality

Insurance Information

Patient Name: _____ Date:____/____/____
(first) (middle) (last)

Mailing Address: _____

Date of Birth: _____/_____/_____ Age: ____ Gender: M / F Marital status: S M D W

Primary Insurance

Insured/Subscriber Name (*if different than self*): _____

Mailing Address *(if different than above):*_____

Date of Birth: ____/____/____ Gender: M / F Relationship: _____

Name of Insurance Company**:** _____

ID#: _____ Group#: _____

Name of Coverage Plan: _____

Secondary Insurance

Insured/Subscriber Name (if different than self): _____

Mailing Address (if different than above): _____

Date of Birth: ____/_____/____ Gender: M /F Relationship: _____

Name of Insurance Company**:** _____

ID#: _____ Group#: _____

Name of Coverage Plan:_____

I hear-by give authorization to Nikol Angel LAc to provide me with East Asian medical services and to also bill and collect payment from my health insurance. I understand that I will be personally responsible for paying any services that may not be covered on my insurance plan. ***I will pay any balance unpaid by my insurance company.*** *If there is a change to my insurance plan and/or coverage, I will inform Nikol Angel LAc to make any necessary adjustments.*

Signature:_____ Date:____/____/___

1029 May Street • Hood River, Oregon 97031 • 541.399.3439
nikol@nikolangelacupuncture.com • nikolangelacupuncture.com