Karma Wellness Center Insurance/Consent to Treat Authorization Form

Please check the appropriate box as it applies: ☐ New Patient ☐ Pending Order ☐ New Insurance ☐ Other: _____

I. Patient Information

Patient Name: _____ Parent Name: _____

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

Home Phone (indicate V or TTY): _____ Date of Birth: _____

Cell Phone: _____ Sex: _____

Email Address: _____

II. Employer Information

Employer Name: _____ Work Phone (indicate V or TTY): _____

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

III. Primary Insurance Carrier Information

Check Health Plan Type (if known): ☐ HMO ☐ PPO ☐ EPO ☐ POS ☐ Medicare ☐ Medicaid

Insurance Company Name: _____ Phone: _____

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

Group Plan Number: _____ Member Name: _____ Date of Birth: _____

ID Number: _____ Relationship to Patient: _____

IV. Secondary Insurance Carrier Information

Check Health Plan Type: ☐ HMO ☐ PPO ☐ EPO ☐ POS ☐ Medicare ☐ Medicaid

Insurance Company Name: _____ Phone: _____

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

Group Plan Number: _____ Member Name: _____ Date of Birth: _____

ID Number: _____ Relationship to Patient: _____

V. Primary Care Physician Information

Primary Care Physician Name: _____ Phone: _____

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

VI. Authorization

I give my consent to treat to Karma Wellness Center. I authorize Karma Wellness Center to release pertinent information about my medical condition for the purpose of securing health insurance benefits information, authorization, or payment for devices or services.

I will provide a current copy of my insurance identification card, policy number, and demographic information to Karma Wellness Center upon request.

I also authorize Karma Wellness Center to act as my representative and on my behalf to secure all authorization necessary from my insurance company regarding a procedure or order involving a Karma Wellness Center medical device, including, if necessary, any appeal of a denial of benefit and in billing to my insurance carrier for services rendered, if necessary.

I understand that I may revoke this authorization at any time by giving my physician or acting representative at Karma Wellness Center a statement to withhold my personal and medical information from that time forward.

Patient's Name: _____ Patient or Legal Guardian's Signature: _____

Relationship to Patient: _____ Date: _____

Karma Wellness Center will endeavor to obtain authorization from your insurance company to reimburse Karma Wellness Center for services or items covered by an authorization. However, there is no guarantee that we will receive authorization or payment. The patient or the patient's guardian remains liable for payment of services or goods received except as otherwise provided by law.