Sage Health Care
Deborah Meyers, CNP, MS
808 Maggie Trail
Durango, CO 81303
Tel: 970-403-8013 Fax: 970-403-8015

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

E – Mail Address: _____

Home Phone: _____ Cell Phone: _____

DOB: _____ Age: _____ Marital Status (circle): S M Other _____ Sex (circle): F M

Social Security Number _____

Employer: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Insurance Company: _____ Phone: _____

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

Insured/Subscriber Name: _____ Subscriber DOB: _____

Insured/Subscriber #: _____ Group #: _____

Relation to Patient (circle): Self Spouse Other: _____

Please read and sign

I understand and authorize payment of all medical benefits to be paid directly to Sage Health Care, LLC /Deborah Meyers, CNP, MS (owner). I hereby authorize Sage Health Care, LLC to release/furnish any medical information necessary for insurance claims. The patient/responsible party is personally and fully responsible for payment of any balance not paid by their insurance within 45 days of billing.

_____ _____

Signature of Patient or Legal Guardian Date