Deana Brooksher, DC
A Garden for Wellness
Insurance Consent Form

Patient's Full Name:_______________________________________
Address:____
City:____________________________________State: ______________
Zip Code:____________

Date of Birth:_________________________

Phone Number:________________________________

Email Address:____

Marital Status: Married/Divorced/Single/Widow

If patient is under age 18, who is the Responsible
Party?__________________________________

Primary Insurance Information:

Name of Insurance Co:_______________________________________

ID Number:___________________________
Group Number:______________________________

Member's Name:_______________________________
Date of Birth:________________________

Employer?______________________________________

Relationship to the Patient?____

Secondary Insurance Information:
Name of Insurance Co:____
ID Number;___________________________
Group Number:_______________________

I authorize the release of any medical or other information to process all claims performed. I also request payment of benefits be made directly to A Garden for Wellness. We are filing insurance as a courtesy to you, therefore if your insurance company fails to pay for any treatment on your behalf, you will be responsible for the balance due. By signing below, I am agreeing to the above mentioned terms and conditions.

Signature of patient or responsible
party:____
Date:__________________________________