

The Village Doc
Susanne Macsay, ND, DDS(Denmark)
Naturopathic Physician
435 NW 4th Street
Corvallis, OR 97330
541-224-7577

**PERSONAL CONTACT
AND
PAYMENT / INSURANCE POLICY**

Legal Name: Last _____ First _____ MI _____

Street Address: _____ Apt. # _____

City: _____ State: _____ Zip Code: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Sex: M _____ F _____ SS#: _____

Employer: _____ Work Phone # _____ Ext: _____

Marital Status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Spouse/Partner's:

Last Name: _____ First _____ MI _____

Date of Birth: _____ Sex: M _____ F _____ SS#: _____

Partner's Employer: _____ Work Phone # _____ Ext: _____

Nearest Living Relative – Someone Other Than Your Spouse/Partner:

Full Name: _____ Relationship _____

Home Phone: _____ Work Phone: _____ Ext: _____

Who Referred You To Our Office? _____

Who Is Your Primary Care Physician? _____

PAYMENT: I understand that I am expected to **PAY THE AMOUNT IN FULL ON THE DAY OF THE APPOINTMENT**, unless other prior arrangements have been made with the doctor.

INSURANCE: I understand that I am solely responsible for filing my claim to my insurance carrier, since the doctor's office does not accept any insurances at this point in time. (Please complete the patient information of your insurance claim form. Attach the bill, signed and dated, and all other bills pertaining to the claim. If you have a deductible policy, hold your claim forms until you have met your deductible. Mail all of it together directly to your insurance carrier).

I have read and completed all the information on this sheet and certify this information to be true and correct to the best of my knowledge. I will notify the doctor of any changes in the above information. I am aware of the policies regarding payment and furthermore consent to treatment by Susanne Macsay, ND, DDS(Denmark).

SIGNATURE: _____ **DATE:** _____