Connecticut Integrated Naturopathics LLC **590 Middlebury Road, Suite B, Middlebury, CT-06762**
Ph: 203 577 2095

Patient Insurance Information

Patient name ____

Patient date of birth ____

Name of insurance plan ____

Patient ID number ____

Insured's name ____

Insured's date of birth ____

Insured's employer ____

I authorize Connecticut Integrated Naturopathics LLC to disclose necessary healthcare information to the above-named company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I request that payment of authorized benefits be made on my behalf to Connecticut Integrated Naturopathics LLC for any services furnished me by Dr. Sharmilee Jayachandran. I understand and agree that regardless of my insurance status I am responsible for the balance on this account for any services, supplements, or laboratory work.

Signature_____________________________________ **Date**_______________