

# Nourishing Wellness

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**Linda Howes**  
Certified Nutritionist  
Holistic Health Practitioner  
Certified Body Ecologist  
[www.NourishingWellness.net](http://www.NourishingWellness.net)

## INSURANCE INFORMATION

### Patient Information

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ M: \_\_\_\_\_  
Date of birth: \_\_\_\_\_  
Mailing address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Hm phone: \_\_\_\_\_ Wk phone: \_\_\_\_\_  
Cell: \_\_\_\_\_ Fax #: \_\_\_\_\_

### Insurance Company Information

Insurance company: \_\_\_\_\_ Policy # \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

### Card Holder Information

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ M: \_\_\_\_\_  
Date of birth: \_\_\_\_\_  
Mailing address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Hm phone: \_\_\_\_\_ Wk phone: \_\_\_\_\_  
Cell: \_\_\_\_\_ Fax #: \_\_\_\_\_  
Employer: \_\_\_\_\_

## HIPAA RELEASE

I hereby authorize the release to my insurance company and other practitioners pertinent information related to my claim and/or treatment.

Print Name: \_\_\_\_\_  
Sign Name: \_\_\_\_\_  
Date: \_\_\_\_\_