

INSURANCE INFORMATION FOR ACUPUNCTURE

PERSONAL & WORK INFORMATION

Date: _____

Patient Name: _____

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

Home Phone: _____ Birthdate: / / M F Social Security # - - Single Married

Occupation: _____ Employed By: _____ Business Address: _____

City: _____ State: _____ Zip: _____ Business Phone: _____ Pager: _____

Mobile: _____ Email: _____

FINANCIAL & INSURANCE INFORMATION

I will pay my balance in full at time of service.

Do you have Medical Insurance that covers Alternative Care Yes No

REQUIRED INFORMATION

Primary Insurance

Insurance Company Name: _____

Address: _____ City _____ ST _____ Zip _____ Phone _____

City: _____ St. _____ Zip: _____ Phone: _____ Adjuster: _____

Policy # _____ Claim # _____ Group or Plan or Program: _____

Secondary Insurance

Insured Name: self _____ Insured Address: _____

Insured City: _____ St. _____ Zip: _____ Insured Phone # _____ Emergency # _____

Insured Social Security # _____ Insured Birthdate: / / _____

Insured Relationship to Patient: Spouse Child Partner _____

How did you learn about our practice? friend ad yellow pages drive-by health professional other: _____

RECORDS RELEASE & ASSIGNMENT OF INSURANCE BENEFITS

I here by authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits to the physician or supplier for services rendered. I further agree that should the amount be insufficient to cover the entire medical expense. **I will be responsible to the Provider for payment of the entire bill.**

Patient Signature or Guardian if patient is under 18 years of age

Date:

