

INSURANCE INFORMATION

Medical Insurance Status: Self Private Insurance Medi-Cal Worker’s Comp

Primary Insurance: _____ Telephone#: _____

Insurance Billing Address: _____

Policy Holder’s Name: _____ Relationship: _____

Policy Holder’s Date of Birth: _____ Policy Holder’s Social Security#: _____

Employer’s Name: _____

Policy# / ID#: _____ Group #: _____

Secondary Insurance: _____ Telephone#: _____

Insurance Billing Address: _____

Policy Holder’s Name: _____ Relationship: _____

Employer’s Name: _____ Policy# / ID#: _____ Group #: _____

How long have you been covered by this insurance? _____

Does your policy cover acupuncture? _____

Insurance Responsibility Statement:

The acupuncture office is happy to assist you in billing your insurance company. Many companies have fixed allowances or percentages based on your contract with them. It is your responsibility to pay the deductible, co-payment, and other balances not paid by your insurance. It is your responsibility to pay for all services provided.

Payment Assignment and Insurance Medical Release:

I hereby assign my insurance benefits to be paid directly to Daniela Freda, L.Ac. for services provided. I understand that I am financially responsible for any non-covered services.

Signature of Patient: _____ Date: _____

I hereby authorize the release of any medical information necessary to process insurance claims.

Signature of Patient: _____ Date: _____