

INSURANCE INFORMATION

Medical Insurance Status: ___ Self ___ Private Insurance ___ Medi-Cal ___ Worker’s Comp
 Patient Status: ___ Married ___ Domestic Partnered ___ Single ___ Divorced ___ Widowed Other _____

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:
Policy #/ ID #:	Group #:

Insurance Coverage for Acupuncture:

How long have you been covered by this insurance? _____
 Does your policy cover acupuncture? _____ What percentage is covered? _____
 Is there a limit to the amount of charges per year? _____
 Are there any exclusions for diagnosis (for example, only for pain or only for nausea)? _____
 Do you have a deductible? _____ Has this deductible been met? _____
 Anything else about your insurance coverage? _____

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: _____