INSURANCE INFORMATION

Medical Insurance Status: ____Self ____Private Insurance ____Other:_____

Name of Primary Insurance:	Telephone #:
Insurance Billing Address:	
Policy Holder's Name:	Relationship:
Policy Holder's Date of Birth:	
Employer's Name:	
Member ID #	Group#:

Secondary Insurance:	Telephone #:
Insurance Billing Address:	Employer's Name:
Policy Holder's Name:	Relationship:
Member 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:_____