

**Insurance Patients Only:**

## **Insurance Information and Assignment of Release Form:**

*\*Please provide us with your insurance card so that we may make a copy.*

Date of Injury or onset: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Contact person/ case manager \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Group/Claim Number/Id number: \_\_\_\_\_

If applicable, Referring or Primary Care Physician: \_\_\_\_\_

Was Injury a result of an accident? \_\_\_\_\_

If yes: Job related? \_\_\_\_\_ If so Employer Information:

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Auto \_\_\_\_\_ Other \_\_\_\_\_

**Do you have an Attorney (if applicable) representing your claim? If so please provide the information below.**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_

I hereby authorize the release of medical information necessary to process my insurance claim and any future insurance claims, without obtaining my signature on each claim. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information to my attorneys, health care providers and insurance case managers.

I am responsible for all charges for all services provided. In the event that the insurance company denies benefits or makes a partial payment, I am responsible for any balance due. This may not apply to insurance companies that I am under contract with. I understand the benefits and risks of Acupuncture and its related modalities and give my consent for those services. I will consult my practitioner with any questions or concerns immediately.

I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes. I agree to provide **24 hour** cancellation notice. If I fail to do so, I agree to pay the **50%** appointment fee. (Please note that insurance companies **do not** pay this, you do.)

Signature \_\_\_\_\_ Date \_\_\_\_\_

