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Insurance Information Form

Please fill out completely

Today's Date: _____

Patient's First Name: _____ M.I.: _____ Last: _____

Address: _____ State: _____ Zip: _____

Home #: _____ Cell/Work #: _____ Date of Birth: _____

Partnership Status: _____ Employment Status: _____

Primary Insurance

Insurance Company Name: _____ Phone: ( ) _____

Claims Address: _____

City, State, Zip Code: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Relationship to patient: ( ) Self ( ) Spouse ( ) Dependent ( ) Other _____

I.D. # as shown on card: _____ Group #: _____

Employer of Insured: _____

Secondary or AUTO Insurance

Is this visit injury related? ( ) Y ( ) N Auto Accident ( ) Y ( ) N * **Please note that at this time, L&I DOES NOT pay for acupuncture**

For Auto Accidents: Did the accident occur in WA State? ☐ Yes ☐ No. If no, what state? _____

Date of Injury: _____ Were you at fault? ☐ Yes ☐ No _____

Insurance Company Name: _____ Phone: ( ) _____

Claims Address: _____

City, State, Zip Code: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Relationship to patient: ( ) Self ( ) Spouse ( ) Dependent ( ) Other _____

Claim # or I.D. #: _____ Group #: _____

Claim Adjuster (if applicable) or Employer of Insured: _____ Phone #: _____

ALL PATIENTS please read and sign below:

- In fairness to the other patients and the practitioner, **24 hours notice is required for cancellation of an appointment, or you will be charged a broken appointment fee of $50.00.**
- Once your insurance coverage has been verified, we will be glad to bill directly to and accept payment from the insurance company. It should be understood that all services are charged to you, the patient, who is legally responsible for payment. The patient agrees to pay all collection costs including, but not limited to reasonable attorney fees, late charges, and litigation costs in the event of any breach, including failure to timely make any payments.
- I hereby authorize the release of my medical records to the above insurance company for the express purpose of payment of my medical bills incurred in this office.
- I hereby authorize the insurance company or attorney (auto accidents) to remit payment directly to this office.

Signature: _____ Date: _____