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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. No Shows will be charged for the full cost of the visit.**
- 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: