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Acupuncturist
10216 63rd Ave. S.
Seattle, WA 98178

INSURANCE INFORMATION FORM

Patient Information

Name_____Phone:_____

Address_____Message #_____

City_____State_____Zip_____

Date of Birth_____Age_____

Who can I thank for referring you?_____

Insurance Information

Insurance Company name_____Phone:_____

Address_____

City_____State_____Zip_____

Name of Insured (if other than self)_____Relationship_____

Insured Date of Birth_____

ID or Claim #_____Group #_____

Employer_____Phone_____

Name of Referring Doctor_____

Accident Information

Type of Accident: ☐Work ☐Auto ☐Other:_____

Date of Accident_____ Location (State)_____

Is the above insurance yours or the other driver's? _____

Name of Attorney_____Phone_____

County_____ Name of other Driver_____

Benefits:

I agree to the release of any medical information my health insurance may need in order to process payment. I assign such benefits to be paid to the above-named provider. In the event that my insurance coverage expires or denies payment, I understand that I am personally responsible for all fees incurred, unless other arrangements have been made.

Signature_____Date_____