ABDC - ACUPUNCTURE BY DENISE COLLINS

PATIENT INSURANCE INFORMATION FORM

FIRST NAME	MIDDLE NAME	LAST NAME
SEX MALE FEMALE	DATE OF BIRTH	SOCIAL SECURITY NUMBER
STREET ADDRESS		CITY, STATE, ZIP CODE
TELEPHONE NUMBERS: HOME	WORK	CELL
EMAIL ADDRESS		
PRIMARY INSURANCE CARRIER NAME AND ADDRESS		
POLICY NUMBER		GROUP NUMBER
NAME OF INSURED	INSURED'S DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S STREET ADDRESS		CITY, STATE, ZIP CODE
SECONDARY INSURANCE CARRIER NAME AND ADDRESS		
POLICY NUMBER		GROUP NUMBER
If this is a No-Fault claim, please furnish: Attorney name & address		Phone number
If this is a Worker's Compensation Claim, please furnish: Compensation case number	File Number	Are you presently working

FOR OFFICE USE:

INSURANCE ACCEPTED YES NO	CO-PAY/ DEDUCTABLE	COMMENTS

I authorize the release of my medical records to Denise Collins LAC. And the release to my insurance carrier needed to determine my benefits for related services.
In the event that the insurance provider does not reimburse in full, I agree to be responsible for any remaining balances.

PATIENT SIGNATURE _____ DATE: _____