Caspian Acupuncture – Insurance Information form

Anita Tayyebi EAMP, LAc. 652 SW 150th St Burien WA 98166

Patient's Name _____Today's Date _____

It is important to verify your coverage prior to your first appointment. Here are some important questions to ask when calling to verify your benefits.

Insurance Company Name _____ Phone #_____

Subscriber's Name_____ Subscriber's DOB_____

Relationship to patient: Self ◯ Spouse ◯ Dependent ◯ other _____

Policy #/ ID # _____ Group #_____

Employer of Insured _____

Is this visit injury related? Y ◯ N ◯ Auto Accident? Y ◯ N ◯

For Auto Accidents: Did the accident occur in WA State? Y ◯ N ◯ If No, what state? _____

Date of Injury: _____ Were you at fault? Y ◯ N ◯

Insurance Rep's name_____

Does my plan cover Acupuncture? Y ◯ N ◯ Provider (Anita Tayyebi) is in my network? Y ◯ N ◯

Is there a limit on the number of Acupuncture visits per year? Y ◯ N ◯ What is the limit? _____

What is my copay amount? _____ What is my coinsurance amount? _____

What is my yearly deductible: _____ Has my deductible been met for the year? Y ◯ N ◯

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 $70.00.
- 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.
- **There are no guarantees of these benefits and your insurance company makes final determination of payment when the actual claim is received**. Any benefit level appeals must be made by the patient.
- 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:_____