Caspian Acupuncture – Insurance Information form

Anita Tayyebi EAMP, L.Ac. Licensed in Washington State, # AC60608107

Patient's Name _____ Today's Date _____

Primary Insurance

Insurance Company Name _____ Phone #_____

Subscriber's Name_____ Subscriber's DOB_____

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

Policy #/ ID # _____ Group #_____

Employer of Insured _____

Secondary Insurance or Auto Insurance

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 Company Name _____ Phone #_____

Subscriber's Name_____ Subscriber's DOB_____

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

Policy #/ ID # _____ Group #_____

Claim Adjuster (if applicable) or Employer of Insured _____

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 $40.00.
- 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:_____**