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

Primary Insurance or Auto Insurance

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.
- 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:_____