

INSURANCE VERIFICATION FORM

PLEASE CALL YOUR INSURANCE COMPANY AND COMPLETE THIS FORM BY ASKING THE FOLLOWING QUESTIONS:

Patient name: _____

Date of call: _____ Time: _____ Spoke to: _____

Insurance Company: _____ Phone # (____) _____

Insured: _____ Relationship to the patient: _____

Policy #: _____ Group #: _____

1. Is Acupuncture covered on this plan? Yes / No
2. Is a referral required from my Primary Care Physician? Yes / No
3. Is pre-authorization required? Yes / No
4. Am I limited to specific diagnosis codes? Yes / No
(If yes, does one of these codes apply to your illness? Yes / No If no, stop here.)
5. Is there a deductible? Yes / No
If yes, what is the deductible? \$ _____ How much has been met? \$ _____
6. Is there a maximum yearly benefit for Acupuncture? Yes / No
Is that per Calendar Year / Fiscal year / Renewal Date?
_____ # of visits per year / per diagnosis / per incident
_____ # of visits used year to date
\$ _____ of Acupuncture care per year \$ _____ used year to date
7. What percentage is covered? _____%
8. Is there a co-payment or leftover percentage that I am responsible for? Yes / No
If yes, what is it? \$ _____
9. Does my plan cover herbal prescriptions? Yes / No
10. Are benefits for other forms of alternative health care (Chiropractic, Massage, Naturopathic) taken from the same pool as Acupuncture? Yes / No

Claims address: _____

City: _____ State: _____ Zip: _____

Please note, benefits stated by a representative cannot be guaranteed.

AMY DARLING, LAC

PO Box 31685
SEATTLE, WA 98103

PATIENT REGISTRATION

Please fill out completely

Patient Name:	MI:	Last:
Street Address:	E-mail:	
City:	State:	Zip:
SSN:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Home ph: () ()
Employer:	Work ph: () ()	
Date of Birth: -- --	Age:	Alt ph: () ()
Employment: <input type="checkbox"/> Employed <input type="checkbox"/> F/T Student <input type="checkbox"/> P/T Student <input type="checkbox"/> Retired <input type="checkbox"/> Other		
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Dependant <input type="checkbox"/> Partnered <input type="checkbox"/> Other		
Responsible Party:	Phone: () ()	
Address:	City, ST, ZIP:	
In emergency contact:	Phone: () ()	
Referred By:		

PRIMARY INSURANCE

Insurance Company Name:	Phone: () ()
Claims Address:	City, ST, ZIP:
Subscriber's Name:	Date of Birth: -- -- SSN:
Subscribers Address:	City, ST, ZIP:
Relationship to you:	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependant <input type="checkbox"/> Other
I.D. # as shown on card:	Group #:
Employer of insured:	Phone: () ()

SECONDARY INSURANCE OR AUTO / L & I

Is this visit injury related? <input type="checkbox"/> Y <input type="checkbox"/> N Work related? <input type="checkbox"/> Y <input type="checkbox"/> N Auto accident? <input type="checkbox"/> Y <input type="checkbox"/> N State: _____	
Insurance Company Name:	Phone: () ()
Claims Address:	City, ST, ZIP:
Subscriber's Name:	Date of Birth: -- -- SSN:
Subscribers Address:	City, ST, ZIP:
Relationship to you:	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependant <input type="checkbox"/> Other
I.D. # as shown on card:	Group #:
Employer of insured:	Phone: () ()

I understand that I am financially responsible for all charges and agree to pay for services. I understand that if I fail to provide complete and accurate billing information at the time of service I may be billed and held responsible for all charges. I understand that if I fail to cancel an appointment at least 24 business hours in advance, I may be assessed a fee. I authorize the doctor to release to my insurance company(ies) any and all information necessary to process my claim. I further authorize that payments be made directly to the physician.

Signature _____

Date _____

