

ACUPUNCTURE AND CHINESE MEDICINE CENTER

Edina Professional Building, Suite 308 • 7250 France Avenue South • Edina MN 55435

Phone: (952) 820-0877

Personal Health Insurance Information

****Please call your insurance to find out your specific contract coverage. Since insurance companies all have different sets of rules and criteria, be aware we will diagnose you based on the symptoms we treat and NOT what your insurance will cover. Please bring your insurance identification card with you on your first visit****

Patient's Name: _____ **DOB:** ____/____/____

Telephone: _____ (H) _____ (B/C)

Member #: _____ Group No.: _____

Effective Date of Coverage: _____ Valid Through: _____

Policy Holder's Name (If different): _____ **Policy Holder's DOB:** ____/____/____

Policy Holder's Member # _____ **Your relationship to Policy Holder:** _____

Insurance Limitation: Max No. Of Visits Allowed Per Year: _____ Deductible: _____

Have you had any acupuncture treatments from another facility within this insurance calendar year? No/Yes

If Yes, How many? _____

If we are a Preferred Provider, and you have a Co-Pay, what is the amount per visit? \$ _____

How much has been deducted? \$ _____

I hereby authorize Acupuncture and Chinese Medicine Center to release requested medical information to my insurance company to collect payment for any charges incurred.

I hereby request that my insurance company send payments directly to Acupuncture and Chinese Medicine Center on my behalf for any service provided to me. I understand that I am responsible for knowing the details of my policy and I am solely financially responsible for all charges related to service(s) rendered to my dependant or myself.

Patient's Signature: _____

Date: _____