# ACUPUNCTURE AND CHINESE MEDICINE CENTER

7600 Parklawn Avenue, Suite 321, Edina MN 55435
Phone: (952) 820-0877

**Personal Automobile / Worker's Comp Insurance Information**

Client Name:_____ DOB: ___/ ___/ ___ (circle one) h/b/c Phone: _____

Client's Insurance Co. Name: _____ Policy Holder: _____

Insurance Co. Address: _____ City/State_____ Zip_____

Insurance Co. Phone: _____Adjuster Name: _____

Claim #: _____Policy #: _____

Date of Accident: _____ Time of Accident: _____

Physician Referral Name: _____ Phone #_____

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 services provided to me. I understand that I am responsible for knowing the details of my policy and am financially responsible for all charges related to service(s) rendered to my dependent or myself. If, for any reason, my insurance carrier does not pay any portion of my bill, I agree to pay my portion promptly.

Client Signature: _____ Date: _____