ACUPUNCTURE AND CHINESE MEDICINE CENTER

7600 Parklawn Avenue, Suite 321, 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: __________________