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 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: ____________

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 serviced 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.

Patient's Signature: ___________________________________ Date: __________________