



Marian Blum
ACUPUNCTURE

INSURANCE FORM

Today's date ____/____/____

Please print legibly:

Patient's last name _____ First Name _____ M.I. _____

Street address (not PO Box) _____ City, zip _____

Phone _____ Patient's birthdate ____/____/____ Check all that apply:

single___ married___ other_____ part-time student___ full-time student___ employed___

Check if reason for visit today is related to: auto accident ___ employment ___ injury or other accident ___

If injury/other accident, explain: _____

Relationship of Patient to Insured: Self ___ Spouse ___ Child ___ Other _____

Insured's I.D. or policy number _____ Group number _____

Primary insurance company _____ Plan name _____

Address _____ City _____ State ___ Zip _____

Phone for benefits _____ Insured's employer or school _____

If Insured is not Patient, complete this section.

Insured's last name _____ First Name _____ M.I. _____

Insured's street address _____

Insured's date of birth ____/____/____ Insured's home phone _____

Do you have a second insurance policy? Yes ___ No ___

If yes, policy holder _____ Name of insurance company _____

If there's a second policy, please complete another Insurance Form for that policy.

Please consider my signature below as a lifetime authorization and request for my insurance carrier to make all payments directly to my physician as well as the authorization for the release of information as requested by my insurance company. I understand that I am responsible for medical fees at the time service is rendered and that I will be refunded for any overpayment when the insurance carrier has started reimbursing my provider. I also understand that I am responsible for any medical fees not paid by my insurance carrier.

Signed _____ Date _____