Patients Insurance Information

Patients Name:

Date of Birth:

Street Address:

City: State: Zip

Gender: Female Male

Marital Status: Single Married Divorced Widowed Other

Employment: Employed F/T Student Retired Other

Primary Insurance

Insurance Company:

Insurance ID#:

Group#:

Subscribers Date of Birth: Gender: F M

Subscribers Address (if different from patients):

Secondary Insurance

Insurance Company:

Insurance ID#

Group #

Subscribers (Primary insured) Name:

Subscribers Date of Birth: Gender: F M

Subscribers address (if different from above)

Relationship to patient: Self Spouse Parent Other

Financial Agreement:

I understand I am financially responsible for all charges and agree to pay for services and agreed upon products. I agree to pay my co-pay at the time of service. If insurance does not pay a claim **within 180 days**, I understand that I am personally responsible for all charges. I also understand it's my responsibility to know the details of my insurance benefits. I authorize Elisha's Family Acupuncture to release to my insurance companies any and all information necessary to process my claims. I further authorize that payment be made directly to Eilsha's Family Acupuncture. I underhand that if I cancel or reschedule an appointment with less than 24 hours notice I will be charged a **missed appointment fee of $50**. I understand my insurance company will not be responsible this fee.

Patients Signature:

Patients name printed:

Date: