

Sarah Contreras, LAc, LMP
Acupuncture Resources, LLC
425/303-3364

INSURANCE INFORMATION

Patient Name _____
Day Phone _____ Evening Phone/Cell _____
Address _____
City _____ State _____ Zip _____
Date of Birth _____ Age _____ Email _____

INSURANCE INFORMATION

Name of Insurance Company _____ Phone _____
Address _____
City _____ State _____ Zip _____
Name of Insured (if other than self) _____
Relationship _____ Insured Date of Birth _____
Insurance ID # / Claim # _____ Group # _____
Employer _____ Phone _____
Name of Referring Physician / Health Care Provider _____

ACCIDENT INFORMATION

Type of Accident: Work Auto Other: _____
Date of Accident _____ Location _____
Is the above insurance yours or the other driver's? _____ Name of other Driver _____
Name of Attorney _____ Phone _____

BENEFITS

I agree to the release of any medical information my health insurance may need in order to process payment. I assign such benefits to be paid to the above named provider. In the event that my insurance coverage expires or denies payment, I understand that I am personally responsible for all fees incurred unless other arrangements have been made. I understand that I will be charged \$25 for all missed appointments or failing to cancel an appointment 8 hours in advance.

Signature _____ Date _____