

INSTILL ACUPUNCTURE

INSTILLACUPUNCTURE.COM
 PHONE: (503) 741-9066
 3417 EVANSTON AVE. N. STE 223
 SEATTLE, WA 98103

Patient Insurance Registration									
Name:									
Middle Name				Preferred Name					
Date of Birth	SSN					Sex	M	F	
Address									
City				State			Zip Code		
Preferred Method of Contact									
Home Phone					Cell Phone				
Work Phone	Ext:				E-mail				
Ethnicity					Language				
Employer Name									

Primary Insurance									
Insurance Company Name:					Phone				
ID# as shown on card					Group #				
Employer of Insured					Phone				
Claims Address					City, State, Zip				
Subscribers Name				Date of birth			SSN		
Relationship to You	Self	Spouse	Dependent	Other:					
Subscribers Address					City, State, Zip				

Secondary Insurance, Auto, or L&I									
Is this visit injury related?	Yes	No	Work related?	Yes	No	Auto accident?	Yes	No	
Insurance Company Name:					Phone				
ID# as shown on card					Group #				
Employer of Insured					Phone				
Claims Address					City, State, Zip				
Subscribers Name				Date of birth			SSN		
Relationship to You	Self	Spouse	Dependent	Other:					
Subscribers Address					City, State, Zip				

I understand that I am financially responsible for all charges and agree to pay for services. I understand that if I fail to provide complete and accurate billing information at the time of service I may be billed and held responsible for all charges. I understand that if I fail to cancel an appointment at least 24 business hours in advance, I may be assessed a fee. I authorize the doctor to release to my insurance company(ies) any and all information necessary to process my claim. I further authorize that payments be made directly to the physician.

Signature

Date