Insurance Information

Do you have insurance that covers acupuncture? Yes No

Health Insurance Company: _____

Health Insurance Address: _____

City: _____ State: _____ Zip: _____

Phone: Adjuster Name: _____ Policy or ID #: _____

Group, Plan or Program: Claim #: _____

Insured Relationship to Patient:

☐ Self ☐ Spouse ☐ Child ☐ Partner

Insured Name: _____ Insured M F

Insured Birthdate: _____

Insured Address: _____

City: _____ State: _____ Zip: _____

Insured Phone #: _____ Emergency #: _____

Records Release & Assignment Of Insurance Benefits

The undersigned hereby authorizes the release of any information relating to claims for benefits submitted. I further agree and authorize Justin Penoyer MS, LAc, DACM to submit claims for benefits, for services rendered, without obtaining my signature on each claim. I (patient) _____ hereby authorize (Insurance Co.) _____ to pay and hereby assign directly to Justin Penoyer all owed benefits. I understand that I am financially responsible for all charges incurred, whether or not they are covered by my insurance company. This authorization shall remain valid until written notice is given by me revoking said authorization.

Signature of Patient _____ Date _____