Patient Health Insurance Information

Patient Name: _____ Phone: _____ D.O.B.: _____

Insurance Company: _____ Phone: _____

Billing Address: _____ City: _____ State: ____ Zip: _____

Insurance ID: _____ Group # :_____ Plan Code: _____

eClaims Payer ID: _____ Effective Date: _____ Plan Year: _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with above stated company/companies and assign directly to Acupuncture & Chiropractic Integrative Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that **the benefits exhibited below are not a guarantee of payment** by my insurance as per my insurance company, and I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient's or Responsible Party's Signature:_____ Date: _____

BELOW IS FOR OFFICE USE ONLY

Date of Verification: Spoke with: Ref #:

ACI Tax ID: 81-3582413 ACI Group NPI: 197-205-8105 ZK NPI: 165-943-4496 ZGA NPI: 197-275-0602

Details: **Orthotics L3030** **Yes No** **DX:**

		Chiropractic Yes No		**Acupuncture Yes No**		**Massage Yes No**	
		In-Network	Out of Network	In-Network	Out of Network	In-Network	Out of Network
Referral Required		Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Clinical Submission		Yes No	Yes No	Yes No	Yes No		
Condition		----------	----------	Any or Specific:	Any or Specific:	----------	----------
Deductible	Total					----------	----------
	met					----------	----------
	remain					----------	----------
Out of Pocket	Total					----------	----------
	met					----------	----------
	remain					----------	----------
Max $ per year						----------	----------
No. of Visits/year	Total					----------	----------
	Used					----------	----------
	Left					----------	----------
Coverage % / Visit						----------	----------
Co-Insurance %						----------	----------
Co-pay						----------	----------
Up to $___ or #___of procedures /___units per day						----------	----------
CPT Codes:						----------	----------
97140 Manl Tx		Yes No	Yes No	Yes No	Yes No	----------	----------
97110 Exercise		Yes No	Yes No	Yes No	Yes No	----------	----------
99202, 99213 Exam		----------	----------	Yes No	Yes No	----------	----------
PT- No. of Visits: ____/c. year: Used: Left:							