

Spirit Path Acupuncture LLC

Cassandra Lidin-Lamon L.Ac. M.Ac. Dipl. Ac.

Insurance Verification Form

Name _____ DOB _____

Insured Name _____ DOB _____

Address _____

Primary Insurance Company _____

Insurance Phone _____

Billing Address _____

Group Number _____ ID Number _____

Deductible \$ _____

Deductible Remaining \$ _____

Acupuncture Coverage \$ per visit _____

visits per year _____

\$ per year _____

Allowable charge covered at _____%

Co-pay \$ _____ In / Out of Network

Stop loss/out of pocket \$ _____

Stop loss met Y N

Assignment and Release: I hereby assign my insurance benefits to be paid directly to the undersigned provider. I am financially responsible for non-covered services. I also authorize the provider to release any information acquired in the course of my examination or treatment to assist with payment by my insurance company.

Signature of Client or Guardian _____ Date _____
