

**Healthpointe Acupuncture  
Insurance Form**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: M / F

Is visit related to accident? Yes / No If so, Date/Place: \_\_\_\_\_

Was accident work related? Y / N

**Worker's Compensation Insurance**

Carrier/Address: \_\_\_\_\_

Claim#: \_\_\_\_\_ Attorney Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Attorney Address: \_\_\_\_\_

**Primary Insurance**

Insured's Name (May be different than patient name) (Last, First, Middle): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: M / F

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer of Responsible Party: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Business Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

Insurance Carrier/Address: \_\_\_\_\_

Subscriber ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

**Additional Insurance (If Applicable)**

Person Responsible for Account (Last, First, Middle): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: M / F

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer of Responsible Party: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Business Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

Insurance Carrier/Address: \_\_\_\_\_

Subscriber ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

**Assignment of Benefits and Release**

I hereby authorize payment directly to Healthpointe Enterprises, Inc. (dba Healthpointe Acupuncture) for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether covered by insurance or not. I authorize Healthpointe Enterprises, Inc. to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Submission to insurance companies is not guarantee of payment. I also understand that a missed appointment fee will be charged to me if I miss an appointment giving less than 24 hours notice. This fee will be the full fee for the services schedule. I understand that this fee will not be covered by insurance and that I will be responsible for paying it myself.

\_\_\_\_\_  
Signature of Patient or Person Authorized

\_\_\_\_\_  
Relationship/Authority

\_\_\_\_\_  
Date