

Amy C. Darling
509 Olive Way, Suite 1358 Seattle, WA 98101

Patient Registration

Please fill out completely

Patient's FIRST Name: _____ MI: _____ LAST: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Email: _____

SSN: _____ Gender: ()M ()F Home ph: (_____)

Employer: _____ Work ph: (_____)

Date of Birth: _____ / _____ / _____ Age: _____ Alt. ph: (_____)

Employment: ()Employed ()F/T Student ()P/T Student ()Retired ()Other

Marital Status: ()Single ()Married ()Partnered ()Divorced ()Widowed ()Dependent ()Other

Referred by: _____

In case of emergency contact: _____ Relationship: _____

Phone: (_____) _____

Primary Insurance

Insurance Company Name: _____ Phone: (_____)

Claims Address: _____

City, State, Zip: _____

Subscribers Name: _____ Date of Birth: _____ / _____ / _____

Relationship to you: ()Self ()Spouse ()Dependent ()Other

I.D. # as shown on card: _____ ()Group #: _____

Employer of Insured: _____

Secondary or AUTO Insurance:

Is this visit injury related? ()Y ()N Auto accident ()Y ()N * Please note at this time L & I DOES NOT pay for acupuncture

Insurance Company Name: _____ Phone: (_____)

Claims Address: _____

City, State, Zip: _____

Subscribers Name: _____ Date of Birth: _____ / _____ / _____

Relationship to you: ()Self ()Spouse ()Dependent ()Other

I.D. Claim # as shown on card: _____ Policy # _____

Employer if applicable: _____ Effective / Date of Injury: _____ / _____ / _____

Please read the following statement carefully before signing:

I, the undersigned, understand and agree 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 will be billed and held responsible for all charges. I understand that if I cancel an appointment with less than 24 hours notice will be charged a \$50 fee. I authorize Amy C. Darling, LAc to release to my insurance company(ies) any and all information necessary to process my claim. I further authorize payment to be directly made to Amy C. Darling, LAc.

Signature: _____ Date: _____

INSURANCE VERIFICATION FORM

PLEASE CALL YOUR INSURANCE COMPANY AND COMPLETE THIS FORM BY ASKING THE FOLLOWING QUESTIONS:

Patient name: _____

Date of call: _____ Time: _____ Spoke to: _____

Insurance Company: _____ Phone # (____) _____

Insured: _____ Relationship to the patient: _____

Policy #: _____ Group #: _____

1. Is Acupuncture covered on this plan? Yes / No
2. Is a referral required from my Primary Care Physician? Yes / No
3. Is pre-authorization required? Yes / No
4. Is acupuncture covered for pre-existing conditions? Yes / No
5. Am I limited to specific diagnosis codes? Yes / No
(If yes, does one of these codes apply to your illness? Yes / No If no, stop here.)
6. Is there a deductible? Yes / No
If yes, what is the deductible? \$ _____ How much has been met? \$ _____
7. Is there a maximum yearly benefit for Acupuncture? Yes / No
Is that per Calendar Year / Fiscal year / Renewal Date?

_____ # of visits per year / per diagnosis / per incident

_____ # of visits used year to date

\$ _____ of Acupuncture care per year \$ _____ used year to date
8. What percentage is covered? _____%
9. Is there a co-payment or leftover percentage that I am responsible for? Yes / No
If yes, what is it? \$ _____
10. Does my plan cover herbal prescriptions? Yes / No
11. Are benefits for other forms of alternative health care (Chiropractic, Massage, Naturopathic) taken from the same pool as Acupuncture? Yes / No

Please note, benefits stated by a representative cannot be guaranteed.