nature works
ACUPUNCTURE & CHINESE MEDICINE

Auto Insurance Information Form

Patient Name ____ Date ______________________

Address____State____Zip___________

Home #____________________Cell/Work #____________________Date of Birth__________

SSN___________________Date of Injury___________

Did the accident occur in WA state? ☐ Yes ☐ No. If no, what state?___________________

Claim Insurance Co. ______________________________Name of Insured________________

Address of Ins. Co.____State____Zip________

Adjuster Name___________________Claim #______________

Phone_________Fax__________

Email_____________________

Attorney Name _________________________________Contact Person___________________

Address____State_____Zip__________

Phone_______________________ Date Retained____________________

ALL PATIENTS please read and sign below:

In fairness to the other patients and the practitioner, 24 hours notice is required for cancellation of an appointment, or you will be charged in full for the time scheduled.

Once your insurance coverage has been verified, we will be glad to bill directly to and accept payment from the insurance company. It should be understood that all services are charged to you, the patient, who is legally responsible for payment. The patient agrees to pay all collection costs including, but not limited to reasonable attorney fees, late charges, and litigation costs in the event of any breach, including failure to timely make any payments.

I hereby authorize the release of my medical records to the above insurance company for the express purpose of payment of my medical bills incurred in this office.

I hereby authorize the insurance company or attorney to remit payment directly to this office.

Signature____Date____________________