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INSURANCE INTAKE FORM

PATIENT

Date of Birth _____
Name _____ Phone (Home) _____
Address _____ Phone (Work) _____

Single _____ Married _____
Employer _____ Male _____ Female _____

PRIMARY PLAN INFORMATION

ID# _____
Plan Name _____ Group # _____
Address _____ Phone # _____

Relationship To Insured

Self _____ Child _____
Spouse _____ Other _____

INSURED INFORMATION, IF OTHER THAN YOURSELF

Name _____
Address _____

SECONDARY INSURANCE INFORMATION

Date of Birth _____
ID# or Claim # _____
Plan Name _____ Adjuster's name _____
Address _____ Date of Injury _____

Phone # _____ Name of Insured _____

I agree to the release of any medical information my health insurance may need in order to process payment. I assign some benefits to be paid to the above named provider in the event that my insurance coverage expires or denies payment.

I understand that I am personally responsible for all fees incurred unless other arrangements have been made.

Signature _____ Date _____