Insurance Intake Form

Orange Poppy Acupuncture

Andrea Beckwith, ME EAMP

PATIENT

Name____

Address____

Employer____

Address____

Date of Birth____

Phone (home)_______________________________ Phone (work)___________________________

Plan Name____

Plan contact number____

ID# _______________________________________ Group #_________________________________

I agree to the release of any medical information that 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 is denied payment, I understand that I am personally responsible for all fees incurred unless other arrangements have been made.

Signature____ date______________________