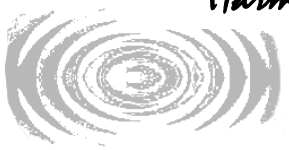

Harmony Acupuncture and Sound Healing

Greg Shannon, L.Ac.

Insurance Verification for Acupuncture

Patient: _____ SS#: _____

Patient's Date of Birth: _____

Health Insurance Information

Insured: _____ SS#: _____

Insured's Date of Birth_____

Name of Insurance Company: _____

Are you also covered by another Health Benefit Plan? No Yes (If yes, please provide that info on the backside of this sheet.)

Phone Number of Insurance Company: _____

Company Billing Address: _____

_____

Policy Number: _____ Group No: _____ Employer: _____

Acupuncture Covered? **Yes** **No** Co-pay per visit: $_____ Referrals Required? **Yes** **No**

Deductible Amount: $_____ Has deductible been met this year? **Yes** **No**

Limits: Maximum Dollar Amount, $_____; or Number of Visits/ year _____

Payment Agreement:

I, the undersigned, agree to assign directly to ***Greg Shannon, L.Ac.*** at ***Harmony Healing Center***, **aka** ***Harmony Acupuncture and Sound Healing***, all insurance benefits, if any, otherwise payable to me for services rendered. I understand, with the exception of specific insurance contracts between the acupuncturist and insurance company, that I am personally responsible for payment of any and all services and/or pharmacy not paid by my insurance company. I hereby authorize the acupuncturist to release all information necessary to secure the payment of benefits. Knowledge of the details, referrals, co-payments and other elements of my insurance plan are my responsibility and therefore the center cannot be held responsible for the financial consequences that may arise from those requirements. Payment for acupuncture services and/or herbs is expected at the time of my visit unless other financial arrangements have been made in advance. I also understand that I am responsible to pay for any visits that are not canceled at least 24 hours in advance of my appointment time. I authorize the use of the signature below on all insurance submissions.

_____ _____

Signature Date