# LOKAHI ACUPUNCTURE INSURANCE VERIFICATION FORM

Patient Name: _____ Date of Birth: ____/____/____

Phone #: (____) _____ - _____ *(Best number to inform you of your benefits)*

Policy Holder's Name: _____ Date of Birth: ____/____/____
Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

Insurance Company: _____ Ins. Phone #: (____) _____ - _____

Member ID#: _____ Group/Policy #: _____

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**Please Read Carefully and Sign Below:** I authorize the release of any medical or other information necessary to process claims submitted to my insurance company or the other responsible party. I also assign the payment of medical benefits directly to Lokahi Acupuncture, Inc. for services provided. I understand that I am fully responsible for my bill and that if attempts to collect payment from my insurance company/responsible party are not successful, I will remit the balance due upon notification. Co-payments and deductibles are due at time of service. I understand if care is discontinued, the balance for care received up to that date is due in full in 30 days.

**Insurance Disclaimer:** Receipt or use of this information does not guarantee payment of any health care, and such information is subject to change, even retroactively, at any time. Insurance verification is not a guarantee of coverage or payment.

I clearly understand and agree that all services rendered me are charged to me. Balances overdue by 60 days may be subject to an 18% APR finance charge or $5.00 per month service charge if payments are not received. Our charges are based on the usual and customary guideline for the area. Our standard charges are:

| | | | |
|---|---|---|---|
| Acupuncture/Office Visit | $85.00-190.00 | New Patient Exam | $50.00 - 110.00 |
| Therapies (each) | $30.00-55.00 | Re-Evaluation Exam | $55.00 – 75.00 |

Information on charges for special services is available from the business office.

Patient/Guardian Signature: _____ Date ____/____/____

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**OFFICE USE:**

Benefit Effective Date: _____ **In Network** / **Out of Network** Benefits:

Max Payable: _____%/Visit $_____/Visit $_____/Year $_____/Condition

Max # Visits: _____ /Week _____/Month _____/Year _____/Condition

Deductible: Individual $_____ Met-to-Date $_____
Family $_____ Met-to-Date $_____

Out/Pocket: Individual $_____ Met-to-Date $_____
Family $_____ Met-to-Date $_____

Verified with:_____ Reference #:_____

By (Lokahi):_____ Date: ____/____/____

NOTES:_____

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Patient notified of findings? ☐
Copy of Ins. Card & License/ID on scanned? ☐
Billing information scanned & set up in OfficePro? ☐