

Pegasus Acupuncture & Natural Health, 2102 North Alder St., Tacoma, WA 98406
Cornelia Moynihan ND, L. Ac
Health Insurance Information Form

Patient Name _____ Date _____
Address _____
City _____ State _____ Zip _____
Home # () _____ Work # () _____ Date of birth _____
Date of injury _____ Referring Doctor _____

In order to bill your private insurance company, please complete the following:

Insurance Co. Name _____ Phone # () _____

Address _____
City _____ State _____ Zip _____

Policy # _____ **Claim #** _____ **Group/Plan #** _____
(Alpha)

Plan or Program Name _____ **Name of insured** _____

Insured Address: _____

City _____ State _____ Zip _____

Insured's Phone () _____ Insured Insurance ID# _____

***** **Insured DOB** _____

Your relationship to the insured ___ **self** ___ **Spouse/Partner** ___ **Child**

Insured Sex ___ Female ___ Male **Insured's employer or school** _____

All Patients, Please read and sign.

Once your insurance coverage has been verified, Pegasus Acupuncture & Herbs will be glad to bill directly and to accept payment from the insurance company. **There is a full visit charge for not giving at least 24 hours notice to cancel an appointment. This fee cannot be charged to your insurance company.**

I understand that I am financially responsible to pay bills that are not paid by the insurance.

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

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

I hereby authorize the release of information to a billing company in order for my insurance to be billed.

Signature: _____ **Date:** _____