Re-Balance Acupunture
Insurance Form

Name of Insured_____

Insured's D.O.B._____

Address With Insurance:_____

Tel #:_____

Primary Insured Company Name:_____

Subscriber ID:_____

Group#:_____

Request that payment of authorized medical benefits be assigned on my behalf to Re-Balance Acupuncture P.L.L.C/Dr. Erica Hsu LAc, for medical services furnished to me by her or under her supervision. I authorize any holder of medical information about me to release to my insurance carrier and its agents any information needed to determine these benefits payable for related services. To avoid misunderstandings regarding acupuncture and insurance we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees unless other arrangements are made in advance. Should your account be tendered to a collection agency for non-payment, regardless of reason, you will be assessed and charged the exact collection fee charged to us to collect.

By Signing I consent to the above

Patient Signature:_____

Print Full Name:_____

Today's Date:_____