

Acupuncture Changes Lives

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How to Verify Whether Your Insurance Pays for Acupuncture:

Fill out this form and fax it to 1-512-236-0097 or email to: billyinaustin@gmail.com

Patient Name: _____ DOB: _____

Patient Address: _____ City/State/Zip: _____

Primary Policy Holder: _____ Relationship: _____ DOB: _____

Insurance Name: _____ Insurance Phone#: _____

Policy ID#, Subscriber# or SS#: _____ Group #: _____

Referring Physician: _____ General Complaint: _____

Upon verification of your Acupuncture and or Physical Therapy benefits, your insurance company has informed us that your In Network or Out of Network benefits are covered as follows: Ok to be performed by LAc? _____

Effective Date: _____ Deductible: _____ Has Met: _____

Co-insurance/Copay: _____ Calendar Year or Plan Year: _____ Pre-cert or Prior Auth required? _____

Max number of visits or dollars per year for Acupuncture: _____

Max number of visits or dollars per year for Physical Therapy: _____

THIS MEANS:

At each visit you are responsible for \$ _____ until your deductible has been met (which is approximately _____ visits). Thereafter you will be responsible for \$ _____ for the remaining _____ visits for each year.

OR:

At each visit you are responsible for a co-payment of \$ _____ for a maximum of _____ visits for each year.

I have read and understand my acupuncture/physical therapy benefits as explained to me. I also understand that this is strictly an estimate and not a guarantee of payment according to my insurance company. I authorize payment of medical benefits to Acupuncture Changes Lives for my treatments. I authorize the release of medical records or other information necessary for the processing of my claims. I understand that this office will bill my insurance company as a courtesy to me, and if for any reason the insurance company does not pay or cover the services, that I will be directly responsible for no more than \$75.00 for the initial visit and \$75.00 thereafter for each visit.

Patient's Signature: _____ Date: ____/____/____

Verified By: _____ Date: ____/____/____ Spoke to: _____ @ _____

Confirmation number for benefits quoted: _____