Gruene Dragon Acupuncture & Oriental Medicine
1308 Common Street, Suite 203
New Braunfels, Texas 78130
P(830) 608-1403 – F(830)608-1400

Kim Jacobs, L.Ac
NPI# 1902210883

NPI# 1912314089

Insurance Benefit Verification

Date:_____/_____/_____

Patient Name:_____ (Male or Female) DOB:_____

Patient Address:_____ City/State_____ZIP:_____

Primary Policy Holder:_____Realtionship:_____DOB:_____

Insurance Name :_____ Insurance Phone#:_____

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

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 Gruene Dragon Acupuncture 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 $100.00 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:_____