CLARITY
ACUPUNCTURE

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# Authorization to Release Information

**Personal Information:**

Patient's Name: Last _____ First _____ MI:____

Patient's DOB: _____ (mm/dd/yyyy) Gender: M__ F __ SSN#_____

Address:_____
City:_____ State:____ Zip:_____ Marital Status: _____
Cell Phone: _____ Home Pone: _____ Work Phone: _____
Emergency Contact Name: _____ Phone: _____

**Insurance Information:**

Insurance Company Name: _____Primary Insured ID#: _____
Insurance plan name: _____ Insurance Group#: _____
Provider Service # (listed on back of insurance card) _____
Primary Insured name: Last:_____ First: _____MI: ____
Primary insured DOB: ___/___/_____ (mm/dd/yyyy)
Patient's relationship to Primary Insured: Self __ Spouse Child Other __

**Please list your major symptoms and concerns:**

_____
_____
_____

Is your health conditions related to work or auto accident? Y__ N __
Date of Loss: _____

Primary Doctor's Name: _____
Allergies: _____
Medication being taken: _____
Nutritional supplements being taken: _____
Other pertinent facts to which this office should be alerted:
_____
_____

How did you hear about us? _____

_____

I,_____, am receiving Acupuncture and related treatments from Kevin Turner L.Ac. I hereby authorize Clarity Acupuncture to verify information required for processing payment, and to collect payment directly from my insurance. I understand that if my insurance fails to cover for my treatments, or pays me directly, I am responsible for making payments. I also authorize the clinic to obtain any medical information on me as needed.

*By signing below, I certify that all information I have provided are accurate and to the best of my knowledge.*

**Client's Name: (Please print): _____Date: _____**

**Client's Signature:_____ Date:_____**

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***For Office's Use Only***

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Date of Treatment:

Diagnosis to be treated:

1)_____ 3)_____

2)_____ 4)_____

Initial Visit Treatment: (please check the following)

Treatments:_____Duration:_____

| | | | | |
|---|---|---|---|---|
| Initial Visit: | 99202___ | 99203___ | 99204 ____ | 99205_ |
| Acupuncture | 1 unit ___ | 2 units ___ | 3 units ___ | 4 units ____ |
| Electrical Acupuncture | 1 unit ___ | 2 units ___ | 3 units ___ | 4 units ____ |
| Manual Therapy: | 1 unit ___ | 2 units ___ | | |
| Ex: (Guasha, Tuina,) | | | | |
| Massage: | 1 unit ___ | 2 units ___ | | |
| Infrared Heat | 1 unit ___ | | | |
| Electrical Stimulation | 1 unit ___ | | | |