IF YOU **WILL BE** USING INSURANCE BENEFITS
THAT COVER SERVICES, PLEASE COMPLETE AND SIGN BELOW:

Insurance Co. _____ Name of insured: _____

Policy# _____ Group# _____

Address: _____ City/State/Zip: _____

I hereby instruct the _____ Insurance Co. to pay by check made out and mailed directly to:

_____ L.Ac.

For the professtional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professtional services rendered.
This is a DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.
This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay in current manner any balance and/or co-pay of said professional service charges over and above this insurance payment.

I further understand that I will be responsible for payment to any other facilities and/or health care providers that may be referred to by _____L.Ac. and any emergency transporting that may be required thereto. I also authorize the release of any information pertinent to my case to any insurance company, adjuster of attorney involved in the case.

Date: _____ Signed: _____ (Patient or insured)

IF YOU **DO NOT** HAVE INSURANCE BENEFITS
THAT COVER SERVICES, PLEASE COMPLETE AND SIGN BELOW:

I hereby acknowledge that I have no insurance that covers services, and I understand that all services are payable when treatment is rendered.

I further understand that I will be responsible for payment to any other facilities and/or health care providers that I may be referred to by _____L.Ac. and any emergency transporting that may be required thereto.

Date: _____ Signed: _____ (Patient or insured)

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, acknowledge that I have received the Notice of Privacy Practices of Elisa K. Wong, L.Ac., Ohana Acupuncture and Herbs, which describe the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the office.
This practice has attempted to provide each patient with a statement of Privacy Policies

Patient Signature: _____

Date: _____