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

Insurance Co. _____ Name of insured: _____
SS#: _____

Policy# _____ Group# _____

Address: _____ City/State/Zip: _____

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

Elisa K. Wong L.Ac.
923 S. Catalina Ave., Suite B
Redondo Beach, CA 90277

For the professtional or medical expense benefits allowable and otherwise payable to m me under my current insurance policy as pyament 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 Elisa K. Wong, 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 Elisa K. Wong, L. Ac and any emergency transporting that may be required thereto.

Date: _____ Signed: _____ (Patient or insured)