EASTERN SCHOLAR HEALING

Insurance and Assignment of Benefits

Patient's Name: _____ Date of Birth: MM / DD / YYYY Sex: ☐M ☐F

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Name: _____ Date of Birth: MM / DD / YYYY Sex: ☐M ☐F

Insured's Address: _____
Street City State Zip

Insurance Information

Insurance Plan Name: _____

Policy or Group Number: _____ Member ID: _____

Provider Phone : _____ (usually listed on the back of your insurance card)

I, the undersigned, authorize payment of benefits be made directly to Judy Tom, L.Ac. and Eastern Scholar Healing for any services provided by Eastern Scholar Healing's health care providers. I authorize Judy Tom, L.Ac. and Eastern Scholar Healing to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services provided. If my health insurance plan will not direct payment to Judy Tom, L.Ac. or Eastern Scholar Healing, I agree to forward to Judy Tom, L.Ac. or Eastern Scholar Healing all health insurance payments, which I receive for the services rendered by Eastern Scholar Healing's health care providers. I authorize the release of any medical or other information required to process any insurance claim. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

I acknowledge I am responsible for all service charges not covered by this assignment. I agree that, if permissible by law, I will reimburse Judy Tom and Eastern Scholar Healing for all costs, expenses and attorney's fees that may be incurred by them to collect any such charges.

_____
Print Insured's Name

_____
Signature of Insured (or Insured's Representative) Date