

**Insurance Authorization Form**

If you do not have insurance or not planning to use insurance, please sign the below form anyway but skip filling out the insurance information. AMU Clinic will not claim health insurance without the patient’s notice. All the insurance patients must sign the AMU Clinic insurance claim record form on each office visit.

如果您沒有保險或不打算使用保險，請在下面的表格上簽字，但不要填寫保險信息。診所不會在沒有通知患者的情況下申報患者的健康保險。所有保險患者必須在每次就診時，在保險使用記錄表上簽署姓名。

Si no tiene seguro o no planea usar un seguro, firme el formulario a continuación de todos modos, pero omita completar la información del seguro. Wenche Chung, MD & Kuoting Lee, Lac Clinic no reclamará seguro de salud sin el aviso del paciente. Todos los pacientes del seguro deben firmar el formulario de registro de reclamos de seguro de la Clínica Wenche Chung, MD & Kuoting Lee, Lac en cada visita al consultorio.

The following declarations must remain in the affirmative and must be factually correct.

Patient Name (Last, First): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Plan Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Contract Group Number of FECA Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Patient Financial Agreement**

I authorize the Wenche Chung, MD & Kuoting Lee, LAc APC, to release my or my minor child’s medical information to the insurance company to determine and receive benefits for medical bills. All the information provided above are current and accurate. I have acknowledged that the Wenche Chung, MD & Kuoting Lee, LAc APC will submit my claim to the insurance company on my behalf.

It is my responsibility to understand the coverage and limitations of my insurance. The cover condition and treatment for the insurance plan are subject to all the terms and coverage benefits of my health insurance. **I understand that my cover condition under my health insurance is not caused by a recent automobile accident and/or work injury.** 我了解我的健康保險不會承包由近期車禍或者工傷引起的身體問題。我將負責任何在保險計劃中沒有支付或者包括的治療費用。

I further understand that I am finally responsible for any charges of treatment and services from Wenche Chung, MD & Kuoting Lee, LAc APC not covered by my insurance plan. This may include copayment, deductible, and co-insurance amount. Copayment and or coinsurance are due at the time of each treatment service.

Any portion of my medical bills not covered by the insurance will be billed to me at the address I have provided above. Non-compliance or defaulting on payments may result in denial of service and/or a legal claim against me for nonpayment. Should I fail to pay an unpaid charge for over 60 days, there will be a monthly service fee charge. Accounts with no activity for 60 days may be forwarded for further collection action. I will be responsible for all the costs of collecting amounts owed, including interest, court costs, collection agency, and attorney fees.

I have read the above statement and agree to abide by the policy.

**Patient Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_