PATIENT PRE-SCREENING FORM

Middle Path Acupuncture & Oriental Medicine

HIPAA requires providers to disclose to patients how their information is handled. Please be sure you have advised patients that benefits will be checked with their insurance company and be sure they have given consent. Indicate this at the bottom of the pre-screening form. Benefits may not be verified without notifying the patient how their information is to be used.

Provider _____ Insurance Carrier _____

Patient Name: _____ Phone # _____

Appointment Date: _____ Time: _____

Patient's Date of Birth _____ Patient's ID# _____

Insured /Policy Holder's Name _____ Date of Birth _____

Insured's Employer _____ Insured's ID #_____

Group ID# _____ Relationship to Patient _____

Is this a managed care plan? Yes _____ No _____ Indicate one: ◉ HMO ○ PPO ○ POS ○ Indemnity

On the back of the insurance card, it may give a phone number for providers to call for benefits or authorization. If so, what is that number? _____

Chief complaint/Reason for appointment: _____

May our billing department call you if they need any additional information? Yes _____ No _____

May we reach you at work if we need to reschedule or speak with you about your account? Yes ____ No _____

May we leave a message with your home answering service if we need to reach you? Yes ____ No _____

Who may we thank for referring you to us? _____

I have advised the patient that our billing department will be inquiring with their health insurance company to verify benefits and to obtain eligibility and any pre-authorization needed. Patient's Verbal Consent: Yes ____ No _____

Signature of provider or representative: _____

Please fax this form to LCMB at 578-1620 or 1-888-578-1620.