ACUPUNCTURE WELLNESS CENTER LLC
EAT WELL - LIVE WELL - BE WELL

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*This form has been prepared to assist you in the completion of your insurance claim form and contains all the information that the practitioner is required to provide. Fill out the personal information requested on your insurance company claim form, and include this statement with the claim form. Each patient, not the insurance company, is responsible for payment to this office*

EIN #: 272303157
NPI #: 1023323920
LIC #: ACA 200029

| Date of Service |
|---|
| |

| Patient Information | Insurance Information |
|---|---|
| Name: ______ ❑ Female ❑ Male | Insurance Carrier: ______ |
| Date of Birth: ______ Age: ______ SS #: ______ | Subscriber/Policy holder Name: ______ |
| Address: ______ | Policy #: ______ Group #: ______ |
| Phone: ______ ❑ home ❑ work ❑ cell | Relationship to patient: ❑ self ❑ spouse ❑ child ❑other: ______ |

I authorize the release of any medical information necessary to process this claim.

Patient's Signature: ______ Date: ______

| DIAGNOSIS | | | | | | | |
|---|---|---|---|---|---|---|---|
| ❑ 789.0 | Abdominal pain | ❑ 595.0 | Cystitis | ❑ 729.1 | Myalgia | ❑ 724.5 | Back Pain (unspecified) |
| ❑ 995.3 | Allergies | ❑ 787.91 | Diarrhea | ❑ 787.02 | Nausea | ❑ 724.3 | Back pain (sciatica) |
| ❑ 300.0 | Anxiety | ❑ 780.4 | Dizziness | ❑ 729.2 | Neuralgia | ❑ 786.50 | Pain, Chest |
| ❑ 716.9 | Arthritis | ❑ 625.3 | Dysmenorrhea | ❑ 724.3 | Sciatic Neuralgia | ❑ 719.41 | Pain, Shoulder |
| ❑ 723.4 | Brachial Neuritis | ❑ 782.3 | Edema | ❑ 473.9 | Sinusitis | ❑ 719.42 | Pain, Elbow |
| ❑ 727.3 | Bursitis | ❑ 692.9 | Eczema | ❑ 726.90 | Tendonitis | ❑ 719.44 | Pain, Wrist / Hand |
| ❑ 354.0 | Carpal tunnel syndrome | ❑ 784.0 | Headache | ❑ 719.47 | Pain, Foot / Ankle | ❑ 723.1 | Pain, Neck / Cervicalgia |
| ❑ 460.0 | Common cold | ❑ 724.2 | Lumbago | ❑ 719.46 | Pain, Knee | ❑ 784.0 | Pain, Face or Head |
| ❑ 564.0 | Constipation | ❑ 780.7 | Malaise / Fatigue | ❑ 719.45 | Pain, Hip | ❑ 780.96 | Generalized pain (NOS) |
| ❑ _____ | ______ | ❑ _____ | ______ | ❑ _____ | ______ | ❑ _____ | ______ |

| CPT | NEW PATIENT | FEE |
|---|---|---|
| ❑ 99201 | Brief evaluation, 10 min | $ 20.00 |
| ❑ 99202 | Limited evaluation, 20 min | $ 30.00 |
| ❑ 99203 | Expanded evaluation, 30 min | $ 40.00 |
| ❑ 99204 | Comprehensive evaluation, 45 min | $ 50.00 |
| ❑ 99205 | Comprehensive evaluation, 60 min | $ 60.00 |
| **CPT** | **ESTABLISHED PATIENT** | **FEE** |
| ❑ 99212 | Limited evaluation, 10 min | $ 20.00 |
| ❑ 99213 | Expanded evaluation, 30 min | $ 30.00 |
| ❑ 99214 | Comprehensive evaluation, 25 min | $ 40.00 |
| ❑ 99215 | Comprehensive evaluation, 40 min | $ 50.00 |

| CPT | ACUPUNCTURE / PROCEDURES | FEE |
|---|---|---|
| ❑ 97810 | Acupuncture, initial 15 min | $ 35.00 |
| ❑ 97811 | Acupuncture, additional 15 min | $ 20.00 |
| ❑ 97813 | Electro-acupuncture, initial 15 min | $ 35.00 |
| ❑ 97814 | Electro-acupuncture, additional 15 min | $ 20.00 |
| ❑ 97026 | Infrared Therapy | $ 15.00 |
| ❑ 97010 | Hot / cold packs | $ 15.00 |
| ❑ 97124 | Massage procedure, 15 min | $ 15.00 |
| ❑ 97140 | Manual therapy techniques (myofascial release), 15 min | $ 15.00 |
| ❑ 97110 | Therapeutic exercises, 15min | $ 15.00 |
| ❑ _____ | ______ | $ 15.00 |

Date of Injury: ______ Condition caused by: ❑ accident ❑ work ❑ illness ❑ other: ______

Date first consulted: ______ Next appointment: ______

Referral: to: ______ instruction: ______

| Provider's Statement | | |
|---|---|---|
| I certify that I have personally rendered the above services and that the charges shown represent my usual charges. | **Today's Charge** | |
| Provider's Signature: ______ Date: ______ | **Payment** | |
| PLEASE REMIT PAYMENT DIRECTLY TO PATIENT | **Balance** | |

SAMPLE