Shinichi Moriyama, L.Ac.
Hollywood Professional Center, Suite 217
3939 NE Hancock St.
Portland, OR 97212

INSURANCE INFORMATION

Name of Insurance Company:_____
Name of Insured:_____ SSN:_____
Group #:_____ Policy #:_____
Address:_____ Phone:_____
City/State/Zip:_____
Name of Adjuster:_____

I agree to be financially responsible for all charges incurred at this office, including my insurance deductible, co-payment, and payment for any services rejected by my insurance company.

_____ _____
Signature (Patient/Parent/Guardian) Date

RELEASE OF INFORMATION

I authorize this office to release any information that is required or necessary for my claim to any insurance company, adjuster, or attorney involved in this case; and hereby release this office of any consequence thereof.

_____ _____
Signature (Patient/Parent/Guardian) Date

ASSIGNMENT

I hereby instruct and direct my insurance company to pay by check made out to and mailed directly to this office, the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this office.

_____ _____
Signature (Patient/Parent/Guardian) Date