

**Acupuncture Health Insurance Claim Form**

**1. PATIENT' S OR AUTHORIZED PERSON' S SIGNATURE**

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to *Eric Serejski, L.Ac.*

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**2. Insured' s or Authorized Person' s Signature**

I authorize payment of medical benefits to Eric Serejski, L.Ac. for services provided.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_