Dr Gamliel
Health & Wellness
drgamliel@gmail.com
www.DrGamliel.com
Phone 786.537.0771

INSURANCE VERIFICATION FORM

Patient Name: ____

Patient Address: ____

City, State, Zip: ____

Patient Phone number: ____

Date of Birth: _______________________ Male/Female: _______________

Patient Subscriber ID #: _______________________________________

Group#: ____

Relationship to insured: _______________________________________

Single/Married/Other: ____

Insurance Company name: ______________________________________

Insurance company phone #: ____________________________________

Claim # if accident: ____

Date of accident/injury: ____

Other info.: ____

If the claim is rejected by the insurance company for any reason, I am financially responsible to for my treatments. I hereby consent to have my credit card billed for the acupuncture services I have received.

Please be mindful of our 24-hour cancellation policy. Any missed appointments/late cancellations will be charged $25.

Signature ______________________

Name: ___________________ Date ___________

Credit Card Type ________ number ________________

Expiration __________ Code____