

**ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO PROVIDER**  
**Private and Group Accident and Health Insurance**

I hereby instruct and direct the \_\_\_\_\_ Insurance Company to pay by check made out and mailed directly to:

**Acupuncture West, LLC**  
**6550 W. Emerald Street, Suite 112**  
**Boise, ID 83704**

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. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in the case.

A photocopy of the Assignment shall be considered as effective and valid as the original.

\_\_\_\_\_  
**Signature of Policyholder**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Claimant, if other than Policyholder**

\_\_\_\_\_  
**Date**

**REQUIRED INSURANCE INFORMATION**

Patient's Information

Patient's Name (First, Middle Initial, Last): \_\_\_\_\_

Patient's Employment Status:    Employed    Full-Time Student    Part-Time Student

Is patient's condition related to employment?    Yes    No

Is patient's condition related to auto accident?    Yes    No

Is patient's condition related to other accident?    Yes    No

Patient's relationship to insured:    Self    Spouse    Child    Other

*If yes, in which state:* \_\_\_\_\_

***The following is required only if different than patient's information:***

Insured's Name (First, Middle Initial, Last): \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_ Insured's Gender: \_\_\_\_\_

Insured's Address: \_\_\_\_\_ Insured's City: \_\_\_\_\_

Insured's State:   Insured's Zip Code:   Insured's Home Phone: \_\_\_\_\_

Insured's Information

Insured's ID Number: \_\_\_\_\_

Insured's Policy Group (or FECA) Number: \_\_\_\_\_

Insured's Employer Name or School Name: \_\_\_\_\_

Insured's Plan Name or Program Name (*if applicable*): \_\_\_\_\_

Is there another health benefit plan?    Yes    No

***If yes, please provide the following:***

Other Insured's Name (First, Middle Initial, Last): \_\_\_\_\_

Other Insured's Policy or Group Number: \_\_\_\_\_

Other Insured's Date of Birth: \_\_\_\_\_ Other Insured's Gender: \_\_\_\_\_

Other Insured's Employer Name or School Name: \_\_\_\_\_

Other Insured's Plan Name or Program Name (*if applicable*): \_\_\_\_\_

\_\_\_\_\_  
**PATIENT SIGNATURE** (Or Patient Representative)  
(Indicate Relationship If Signing For Patient)

\_\_\_\_\_  
**DATE**

## GENERAL PAIN INDEX QUESTIONNAIRE

We would like to know how much your pain *presently* prevents you from doing what you would normally do. For each category below, please indicate the *overall* impact that your pain has on your life.

Please *circle the number* which best describes how your *typical level of pain* affects these six categories of activities.

**1. FAMILY/AT-HOME RESPONSIBILITIES** SUCH AS YARD WORK, CHORES AROUND THE HOUSE, OR DRIVING THE KIDS TO SCHOOL:

0      1      2      3      4      5      6      7      8      9      10

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COMPLETELY ABLE TO FUNCTION TOTALLY UNABLE TO FUNCTION

**2. RECREATION** INCLUDING HOBBIES, SPORTS, OR OTHER LEISURE ACTIVITIES:

0      1      2      3      4      5      6      7      8      9      10

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COMPLETELY ABLE TO FUNCTION TOTALLY UNABLE TO FUNCTION

**3. SOCIAL ACTIVITIES** INCLUDING PARTIES, THEATER, CONCERTS, DINING OUT, AND ATTENDING OTHER SOCIAL FUNCTIONS:

0      1      2      3      4      5      6      7      8      9      10

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COMPLETELY ABLE TO FUNCTION TOTALLY UNABLE TO FUNCTION

**4. EMPLOYMENT** INCLUDING VOLUNTEER WORK AND HOMEMAKING TASKS:

0      1      2      3      4      5      6      7      8      9      10

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COMPLETELY ABLE TO FUNCTION TOTALLY UNABLE TO FUNCTION

**5. SELF CARE** SUCH AS TAKING A SHOWER, DRIVING, OR GETTING DRESSED:

0      1      2      3      4      5      6      7      8      9      10

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COMPLETELY ABLE TO FUNCTION TOTALLY UNABLE TO FUNCTION

**6. LIFE SUPPORT ACTIVITIES** SUCH AS EATING AND SLEEPING:

0      1      2      3      4      5      6      7      8      9      10

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COMPLETELY ABLE TO FUNCTION TOTALLY UNABLE TO FUNCTION

PATIENT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_