

Insurance Information

Patient Name _____

Primary Insurance Company _____

Policyholder's Name _____ Date of Birth _____ Social Security # _____

Relationship to Patient _____ Policyholder's Employer _____ Phone() _____

Secondary Insurance Company _____

Policyholder's Name _____ Date of Birth _____ Social Security # _____

Relationship to Patient _____ Policyholder's Employer _____ Phone() _____

Financial Payment Policy

Responsible Party Must Sign (Must be at least 18 years of age)

The undersigned hereby authorizes the release of any information to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered, or for services to be rendered without obtaining my signature on each and every claim to be submitted by myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

Insurance is considered a method of reimbursing the doctor for services rendered, and not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures, and other insurance companies pay a percentage of the charge. It is my responsibility to pay the deductible amount, co-insurance, out of network% and or any other balance not paid by my insurance company. Payment is expected at the time services are rendered.

If you are in need of special payment arrangements, please see the receptionist.

I hereby understand the financial policy stated above.

Print Name _____

Signature _____ Date _____