

INSURANCE AND BILLING INFORMATION

Date _____

SS/HIC/Patient ID# _____ Date of Birth _____

Patient Name _____
Last Name First Name Middle Initial

Who is responsible for this account? _____

Relationship to Patient _____ Date of Birth _____ Social Security # _____

Insurance Company _____

Insurance Company Address _____

Group #/Policy # _____ Identification # _____

Secondary Insurance Information

Is patient covered by additional insurance? Yes No

Subscriber's Name _____ Date of Birth _____

Social Security # _____ Relationship to Patient _____

Insurance Company _____

Insurance Company Address _____

Group #/Policy # _____ Identification # _____

Insurance Assignment and Release

I certify that I (and/or my dependent(s)) have insurance coverage with _____ and assign directly to Dr. _____

Name of Insurance Company(ies)

all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Medicare/Medigap Authorization Medicare No. _____ Medicare No. _____

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to: _____ for any services furnished

Name of Doctor, Clinic, Healthcare Provider or Supplier

to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature of Beneficiary, Guardian or Personal Representative

Date

Please print name of Beneficiary, Guardian or Personal Representative

Relationship to Beneficiary