INSURANCE INFORMATION

Appointment Date _____ Account # _____

Name of patient _____DOB _____

Full Address_____

Best Phone Number_____Home /wk/cell_____

Reason for new insurance: New patient_____ New job_____ Co. changed insurance _____ other ____

PRIMARY COVERAGE	SECONDARY COVERAGE
Subscriber Name _____	Subscriber Name _____
Date of Birth _____	Date of Birth _____
Social Security # _____	Social Security # _____
Insurance ID # _____	Insurance ID# _____
Employer _____	Employer _____
Insurance Co. _____	Insurance Co. _____
Insurance Co. Address _____	Insurance Co. Address _____
_____	_____
Insurance Phone # _____	Insurance Phone # _____
Group Number _____	Group Number _____
Coverage: Individual ( ) Family ( )	Coverage: Individual ( ) Family ( )

List Covered Family Members	Date of Birth	Relationship to insured

PLEASE READ: Your signature serves as an assignment of benefits for your insurance coverage and as a release of information to your insurance company. Once verified we will submit your claims to your insurance for payment as a courtesy of this office. Payment is required on the date of service for the deductible and any estimated uncovered portion of your visit. If insurance will only pay you directly, payment will be due at the time of service unless arrangements are made ahead of time with our financial coordinator.

I understand and agree that I will be responsible for any balance not covered by insurance, to be paid in full within 30 days. In the event that my account is turned over to a collection agency, I understand and agree I will be responsible for collection fees, court cost, etc, any returned checks will be assessed at a $35.00 fee.

I have read, understand and agree to the office policies stated above.

X _____ Date _____