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INSURANCE INFORMATION

Name of Insured:____

Insured's DOB: ____________________

Name of Insurance Company: ___________________________________

Address (Back of Card): ______________________________________

City:_______________________ Phone:_______________________

Policy/ ID# :___________________ Group #:___________________

PAYMENT

I agree to be financially responsible for all charges incurred at this office, including my insurance deductible, co-payment, and any services rejected by my insurance company.

RELEASE OF INFORMATION

I also authorize this office to release any information that is required or necessary for my claim to an insurance company, adjuster, or attorney involved in this case; and hereby release this office of any consequences thereof.

ASSIGNMENT

I hereby instruct and direct my insurance company to pay by check, made out and mailed directly to this office, the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for service rendered by this office. I give this office power of attorney to endorse checks made out to me, to be credited to my account.

______________________________ ______________________________
Signature of Patient or Legal Guardian *Date*

OFFICE USE ONLY

Today's Date: ______________ **Co-pay:** _________ **Paid at (%):** __________

Deductible: ___________ **Met:** ___________ **Max:** ___________ **Used:** __________

Notes: ____

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