Insurance Information

PATIENT NAME: _____ **DATE:** _____

Primary Insurance

Name of Insurance Company: _____

Policy Holder Name:_____ Policy Holder Date of Birth: _____

Policy Holder Social Security Number:_____

Policy ID Number:_____Group Number: _____

Secondary Insurance

Name of Insurance Company: _____

Policy Holder Name:_____ Policy Holder Date of Birth: _____

Policy Holder Social Security Number:_____

Policy ID Number:_____Group Number: _____

Our office will file with your insurance for all reimbursable services to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductibles, co-pays, and non-covered service amounts.

_____ I authorize the release of any medical information necessary to process my claim.
INITIAL

_____ I understand I must notify my provider's office within **3 business days if my insurance changes or cancels.**
INITIAL

_____ **I understand my copayment is due at the time of the visit**.
INITIAL

Signature of Patient/Legal Guardian: _____