CONFIDENTIAL

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. _____ all insurance
Name of Insurance Company (ies)

benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges 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._____

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 to me by that provider. To the extent
Name of Doctor, Clinic, Healthcare Provider or Supplier

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