INSURANCE INFORMATION

Name of patient _____ Date _____

INSURANCE SUBSCRIBER INFORMATION

Subscriber Name_____ Birth Date_____

Social Security Number _____-_____-_____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_____
Employer _____	Employer _____
Insurance Co. _____	Insurance Co. _____
Ins. Co. Address _____	Ins. Co. Address _____
_____	_____
Insurance Phone #_____	Insurance Phone # _____
Group Number _____	Group Number _____
ID Number _____	ID 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 any 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 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 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, attorney fees, court costs, etc, and 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_____