**INSURANCE INFORMATION**

Name of patient _____DOB _____

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 _____**