INSURANCE DATA

Clinic policy requires payment arrangements be made on first visit.

NAME OF PERSON RESPONSIBLE FOR PAYMENT_____

Please check appropriate coverage.

___I have no health insurance coverage.

___Group or private health insurance.

___Medicare

___PPC or HMO

___Auto-insurance

___Medicaid

___Workers Compensation

___Other_____

Fill out policy information as completely as possible. If you do not know some of the information and it's not listed on your card, it may not apply to you, ask the receptionist.

NAME OF COMPANY_____

PHONE NO._____EXT._____DEPARTMENT_____

ADDRESS_____CITY_____STATE_____ZIP_____

POLICY HOLDERS NAME_____

SOCIAL SECURITY #_____DATE OF BIRTH_____

POLICY HOLDERS RELATIONSHIP TO PATIENT_____

POLICY #_____GROUP #_____

IS PRE-AUTHORIZATION NECESSARY BEFORE TREATMENT: YES / NO

IF YES, AUTHORIZATION NO._____GIVEN BY_____

Would you like us to verify the requirements of your policy: YES / NO

PLEASE READ THE BELOW AND SIGN WHERE INDICATED.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

PATIENT'S SIGNATURE_____