INSURANCE INFORMATION

- Please keep in mind: You are responsible for any insurance nuances that prevent payment and will need to contact your insurance on your own behalf to resolve any issues (i.e., providing incorrect information, non-payment due to eligibility of benefits being incorrect, insufficient funds if using health savings account, ect.). In these instances, full payment for services rendered will be due within 30 days of service. More information can be found on the Good Faith Estimate form.

Primary Insurance Company_____

Phone_____

Ins. claims address_____

City_____State_____Zip_____

Policy/ID number_____Group/Plan number_____

Effective Date_____

Policy/Plan holder information (If the client is not the employee/policy holder)

Name_____Relationship_____

Address_____City_____State_____Zip_____

Date of Birth_____SSN_____Employer_____

Responsible party (where should the patients' portion of the bill be sent, if patient is a minor?)

Name_____Relationship_____

Address_____phone_____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance 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 hereby authorize the healthcare provider to release all the information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature_____

Relationship to patient_____

Date_____