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



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