

Insurance Information

Patient Last Name _____ First Name _____ Middle _____

Insurance Type (Check all those that apply)

Self Insurance (Consumer Directed)	Employee Sponsored (Private Sectors)	Governments (Public Sectors)	Other Types
<input type="checkbox"/> Personal Health Insurance (not sponsored by employer)	<input type="checkbox"/> Group Health Insurance	<input type="checkbox"/> Medicare Part B	<input type="checkbox"/> Auto Injury
<input type="checkbox"/> Health Savings Account (HSA)	<input type="checkbox"/> Self Funded Benefit Plan	<input type="checkbox"/> Medicare Part C	<input type="checkbox"/> Workers' Compensation
<input type="checkbox"/> Other _____	<input type="checkbox"/> Private Schools	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Church
_____	<input type="checkbox"/> Health Reimbursement Arrangement (HRA)	<input type="checkbox"/> Municipal (city, state, etc.)	<input type="checkbox"/> Other _____
		<input type="checkbox"/> Other _____	_____

Insurance We need a copy of your cards for our records.

Insurance Company _____	Phone # () _____
Insured's Name _____	ID/Policy # _____
Insurance Company _____	Phone # () _____
Insured's Name _____	ID/Policy # _____
Insurance Company _____	Phone # () _____
Insured's Name _____	ID/Policy # _____

Responsible Party complete this section if you are not the patient but are responsible for the bill.

Responsible Party _____

Relationship to Patient _____ SS# _____

Home Address _____ Apt# _____

City _____ City _____

Home Phone # _____ Work Phone # _____

Employer Name _____ Occupation _____

My Financial Responsibility

I certify that the above information is correct. I understand that I am personally financially responsible for all services not paid for by my insurance. I am also responsible for any annual deductibles applicable, co payments, or non-covered services as may be required by my insurance plan.

 Signature of patient or person acting on patient's behalf Date

My Authorization

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

 Signature of patient or person acting on patient's behalf Date