

# 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