

INSURANCE INFORMATION

Patient Last Name	First Name	Middle
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INSURANCE TYPE Check all those that apply

SELF INSURANCE (CONSUMER DIRECTED) <input type="checkbox"/> Personal Health Insurance (not sponsored by employer) <input type="checkbox"/> Health Savings Account (HSA) <input type="checkbox"/> Medicare Savings Account (MSA) <input type="checkbox"/> Other _____	EMPLOYER SPONSORED (PRIVATE SECTORS) <input type="checkbox"/> Group Health Insurance <input type="checkbox"/> Self-Funded Benefit Plan <input type="checkbox"/> Private Schools <input type="checkbox"/> Health Reimbursement Arrangement (HRA)	GOVERNMENTS (PUBLIC SECTORS) <input type="checkbox"/> Medicare Part B <input type="checkbox"/> Medicare Part C <input type="checkbox"/> Medicaid <input type="checkbox"/> Municipal (city, state, etc.) <input type="checkbox"/> Other _____	OTHER TYPES <input type="checkbox"/> Personal Injury (Auto, etc.) <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> Church <input type="checkbox"/> Other _____
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INSURANCE We need a copy of your card(s) 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 _____ State _____ Zip _____

Home Phone # _____ Work Phone # _____

Employer Name _____ Occupation _____

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.

x _____

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

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, copayments, or non-covered services as may be required by my insurance plan.

x _____

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