

4

Insurance Information**Primary Insurance**

Name of Insured _____
 Relationship to patient _____
 Insured's birthdate _____
 SS#/SIN _____
 Employer _____
 Date Employed _____
 Occupation _____
 Insurance Company _____
 Group # _____
 Employee/Cert. # _____
 Ins. Co. Address _____
 Deductible _____
 Amount already used _____
 Max. annual benefit _____

Additional Insurance

Name of Insured _____
 Relationship to patient _____
 Insured's birthdate _____
 SS#/SIN _____
 Employer _____
 Date Employed _____
 Occupation _____
 Insurance Company _____
 Group # _____
 Employee/Cert. # _____
 Ins. Co. Address _____
 Deductible _____
 Amount already used _____
 Max. annual benefit _____

5

Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X

 Signature of patient or parent /guardian if minor

 Date

6

Financial Arrangements

For your convenience, we offer the following methods of payment.
 Please check the option which you prefer.

Payment in full at each appointment.

_____ Cash

_____ Personal Check

_____ Credit Card _____ Visa _____ MC

_____ I wish to discuss the office's payment policy.

Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional services except for emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask - we are always happy to help.