MEDICAL / HEALTH INSURANCE INFORMATION

Primary Insurance Company	
Insurance ID Number	
Insurance Primary Member Name	Primary Member Date of Birth
Relationship to Subscriber (Please Circle One): Self Spouse Dependent Child	
Secondary Insurance Company	
Insurance ID Number	

Please present any insurance cards and forms to the receptionist.

MEDICAL INSURANCE POLICY:

_____ (Initial) I authorize the release of any medical or other information to process my insurance claims.

_____ (Initial) I understand that I am responsible for any charges not covered by my insurance.

_____ (Initial) I authorize payment of medical benefits to my doctor.

_____ (Initial) It is my understanding that I am responsible to obtain any and all referrals that my insurance company requires for service performed by that doctor. A lack of referral can result in your appointment being cancelled or rescheduled.

PAYMENTS / CANCELLATION / NO SHOW POLICY:

_____ (Initial) All co-pays and any previous balances are due at the time of visit.

_____ (Initial) Returned checks will be assessed a fee of $25.00.

_____ (Initial) Failure to notify us of cancelled or rescheduled appointements within 48 hours may result in a fee of $25.00.

Patient Name (Please Print)	Date
Patient Signature	