Private Health Insurance Information Form

Patient Name_____ Date_____

Address_____ City_____ State____ Zip_____

Home # (___)_____ Work # (___)_____ Date of Birth_____

SS#_____ Date of Injury_____ Referring Doctor_____

In Order To Bill Your Private Health Co. Please Ask For An Insurance Verification Form And Please Complete The Following:

Insurance Co: Name _____ Phone #(___)_____

Address_____ City_____ State_____ Zip_____

Policy #_____ ID _____ (ALPHA) # _____ Group/Plan #_____

Plan or Program Name_____ **Name of Insured** _____

Insured's Address _____ City_____ State____ Zip_____

Insured's Phone (___)_____ Insured's SS#_____ Insured's Date of Birth_____

Your Relationship to Insured ☐ Self ☐ Spouse/Partner ☐ Child

Insured's Sex ☐ Female ☐ Male **Insured's Employer or School** _____

Please read and sign below:

In fairness to our other patients and to us, 24 hour notice is required for cancellation of an appointment, or you will be charged in full for the time booked.

Once your insurance coverage has been verified, we will be glad to bill directly to and accept payment from the insurance company. It should be understood that all services are charged to you, the patient, who is legally responsible for payment. Patient agrees to pay all collection costs including, but not limited to reasonable attorney fees, late charges and litigation costs in the event of any breach, including failure to timely make any required payments.

I hereby authorize the release of my medical records to the above insurance company for the express purpose of payment for my medical bills incurred in this office.

I hereby authorize the insurance company or attorney to remit payment directly to this office.

Signature: _____ **Date:**_____

(Patient / Parent / Guardian)