

**PATIENT INSURANCE INFORMATION**

Insurance information (Please present Insurance card at time of check in)

**PRIMARY**

Insurance Name \_\_\_\_\_  
Ins Address \_\_\_\_\_  
Name of Insured \_\_\_\_\_  
Insured ID # \_\_\_\_\_  
Group # \_\_\_\_\_  
Employer \_\_\_\_\_  
Employer Address \_\_\_\_\_  
\_\_\_\_\_  
Employer Phone \_\_\_\_\_  
Relationship of patient to insured \_\_\_\_\_  
\_\_\_\_\_

**SECONDARY**

Insurance Name \_\_\_\_\_  
Ins Address \_\_\_\_\_  
Name of Insured \_\_\_\_\_  
Insured ID # \_\_\_\_\_  
Group # \_\_\_\_\_  
Employer \_\_\_\_\_  
Employer Address \_\_\_\_\_  
\_\_\_\_\_  
Employer Phone \_\_\_\_\_  
Relationship of patient to insured \_\_\_\_\_  
\_\_\_\_\_

Pharmacy of choice \_\_\_\_\_  
Phone \_\_\_\_\_

In case of Emergency, Who should be notified? \_\_\_\_\_  
Phone \_\_\_\_\_

Primary Care Physician:  
\_\_\_\_\_

I authorize the release of medical information to my primary care of referring physician, to consult if needed and as necessary to process insurance claims, Insurance Applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party  
Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event of major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services and co-payments. In the event that your account must be turned over to collections, a \$25.00 collections fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party  
Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

OUR OFFICE WILL ONLY BILL BLUE CROSS BLUE SHEILD, WIN HEALTH, TRICARE, MEDICARE AND MEDICAID.  
UNLESS YOUR BILL FOR THE DAY YOU WERE SEEN IS OVER \$200.00 OR PRIOR ARRANGEMENTS HAVE BEEN MADE

Please present insurance cards to receptionist so copies may be made.