Complete only if using insurance

Insurance: _____ Deductible: _____ Deductible met? Y / N

Employer & Address: _____

Insured's SS#: _____ Driver's License No. _____ State: _____

Full Name of spouse: _____ SS#: _____

Spouse's Employer: _____ Phone: (___) _____

Insured's Primary Ins. Company: _____

ID. No: _____ Group No: _____

Secondary Ins. Co: Y / N Company:_____ Policy No: _____

Job Related Injury-Workmens Comp. Co: Y / N Company: _____

Office Billing and Insurance Policy

1. I authorize use of this form on all of my insurance submissions.
2. I authorize the release of information to my insurance company(s).
3. I understand that I am responsible for the full amount of my bill for services provided.
4. I authorize direct payment to my service provider.
5. I hereby permit a copy of this to be used in place of an original.

Name: _____ ID #: _____

Signature: _____ Date: _____

It is your responsibility to pay any deductible amount, co-pay, co-insurance amount or any other balance not paid by your insurance the day and time serviced provided.

There will be a $25.00 service charge on all returned checks.

In event that your account goes to collections, there will be a $20 collection fee added to your balance.

There is a 24-hour cancellation policy which requires that you cancel your appointment 24 hours in advance to avoid being charged.

Signature: _____ Date: _____