18 AND OVER PATIENT INFORMATION SHEET

Patients Name_____ **Date of Birth**_____
Social Security #_____ Home #_____
Address _____ Cell #_____
City_____ State_____ Zip_____
Employer _____ Work #_____
E-mail_____

Primary Insurance
Name of Insured Parent_____ Date of birth_____
Name of Insurance_____ Co-Pay_____
ID # _____ Group #_____
Address for Insurance Claims _____

Secondary Insurance
Name of Insured Parent_____ Date of birth_____
Name of Insurance_____ Co-Pay_____
ID # _____ Group #_____
Address for Insurance Claims _____

FINANCIAL RESPONSIBILTY FORM

In most cases your insurance company does not cover our fee service in full. We want you to be aware of the fact that you are responsible for any balance due after the insurance payment. This balance due includes provisions set by your insurance company, such as co-payments, deductibles, and "usual and customary" allowances.

The policy held by you and/or your guardian is a contract between the policyholder and the insurance company. Providers do not accept companies as patients. YOU are our patients.

If you are not familiar with your insurance coverage, we ask that you discuss your policy with your insurance company BEFORE charges are incurred.

I understand that I am financially responsible for any charges and or fees incurred and promise to pay promptly the amount of such charges that are not paid by any insurance carrier for any reason.

_____ Date_____
Signature

AUTHORIZATION FOR THE RELEASE OF RECORDS

I authorize the release of any medical or financial information to any insurance company necessary to process a claim benefit. In addition, I authorize the release of payment of medical benefits for all services performed.

_____ Date_____
Signature