

# Insurance Information Form

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

<b>Insurance Co. Name</b> _____	<b>Phone #</b> ( ) _____
<b>Address</b> _____	<b>City</b> _____ <b>State</b> _____ <b>ZIP</b> _____
<b>Policy #</b> _____	<b>Claim #</b> _____ <b>Group/Plan #</b> _____
<b>Plan or Program Name</b> _____	<b>Name of Insured</b> _____
<b>Insured's Address</b> _____	<b>City</b> _____ <b>State</b> _____ <b>ZIP</b> _____
<b>Insured's Phone #</b> ( ) _____	<b>Insured's SS#</b> _____ <b>Insured's Date of Birth</b> _____
<b>Your Relationship to Insured</b>	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Child
<b>Insured's Sex</b>	<input type="checkbox"/> Female <input type="checkbox"/> Male <b>Insured's Employer or School</b> _____

## PLEASE READ AND SIGN BELOW

**No Insurance** (Please Circle):

Payment is expected at time of treatment.

**ALL PATIENTS, 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)