Office Use Only
Onset_____
FV_____
Dx _____
CoPay _____

INSURANCE INFORMATION

PLEASE PRINT CLEARLY: This information needs to be accurate to avoid rejection of the insurance claim made on your behalf.

Name of Insurance Plan (on card) _____

Address of Insurance Plan _____

_____

Phone Number of Insurance Company (on card) _____

Name of Insured _____

Address of the Insured Street _____

City and State_____

Zip Code_____

Phone Number _____ **Insured's Date of Birth** _____

ID # _____**Group #**_____

Employer _____

****

Name of Patient _____

Address of the Insured Street _____

City and State_____

Zip Code_____

Phone Number _____**Patient Date of Birth**_____

Patient Status ❑ **Single** ❑ **Married** ❑ **Other**

❑ **Employed** ❑ **Full Time Student** ❑ **Part Time Student**

****

I authorize release of any information needed to process my insurance claim.

Your Signature _____ **Today's date**_____

****

I authorize payment of medical benefits to Gloria Waite for services provided to me. I understand that I hold the responsibility of payment, if the insurance company does not make payment for these services.

Your Signature _____ Today's Date_____