PRACTICE NAME

ADDRESS, TELEPHONE AND FAX

BILLING & FINANCIAL POLICY

Insurance & Payment Authorization

PATIENT & POLICYHOLDER

PATIENT NAME

DATE OF BIRTH

POLICYHOLDER NAME (IF NOT PATIENT)

RELATIONSHIP TO PATIENT

PRIMARY INSURANCE

CARRIER

MEMBER ID

GROUP #

SECONDARY INSURANCE (OPTIONAL)

CARRIER

MEMBER ID

GROUP #

ASSIGNMENT OF BENEFITS

I authorize the practice named at the top of this form to release the medical and billing information needed to process my insurance claims, and I authorize payment of benefits directly to that practice for services rendered. I understand that I am responsible for any deductible, copay, coinsurance, or non-covered service.

PAYMENT METHOD ON FILE (OPTIONAL)

☐ Card on file for copay and coinsurance only ☐ Bill me by mail ☐ Self-pay

POLICYHOLDER SIGNATURE

DATE