For Provider Use ONLY:

Provider Name: **Diagnosis Code:**

Referring Provider: **Authorization #:**

COMPLETE AND ACCURATE INFORMATION IS REQUIRED

PATIENT

Patient Name_____ SS#_____

Address_____

City_____State_____Zip_____

Date of Birth_____ Male _____ Female_____ Marital Status_____

Home Phone_____ Work Phone _____

RESPONSIBLE PARTY Name & address of person responsible for any balance not covered by insurance:

☐ Same as Patient ☐ Other

Name_____

Address_____ City_____State_____Zip_____

Home Phone_____ Work Phone _____

INSURANCE Include copy of front & back of insurance card

Primary Insurance_____

Insurance Address_____Phone_____

City_____State_____Zip_____

Subscriber #: _____ Group#: _____

Secondary Insurance_____

Insurance Address_____Phone_____

City_____State_____Zip_____

Subscriber #: _____ Group#: _____

SUBSCRIBER

☐ Same as Patient ☐ Same as Responsible Party ☐ Other

Subscriber Name_____ Date of Birth _____ SS#_____

Patient Relationship to subscriber: Self____ Spouse____ Child____ Other (specify)_____

Employer_____Phone_____

INSURANCE AUTHORIZATION AND ASSIGNMENT: I hereby authorize the Provider of service to furnish information to insurance carriers concerning my condition and treatment. I hereby assign to the provider all payments for medical services rendered to my dependents or myself. I hereby authorize the Provider to share my information with any third party service for which they have a fully executed HIPAA Business Associate Agreement. I UNDERSTAND I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

Signature_____ Date _____

FAX# 781 784 0996