Insurance Information

(to be completed by the patient)

Name of Policy Holder:_______________________ Policy Holder DOB:__________________

Your relationship to Policy Holder:_______________ Policy Holder SSN:__________________

Insurance Company:____

ID #:___________________________ Group #:___________________

Our Policy

(please read and initial each paragraph)

As a courtesy to you, the patient, we will contact your insurance company to check your coverage at the time of your initial visit. ***Benefits quoted are not a guarantee of payment; all services are ultimately the responsibility of the patient for payment.***

Our office will directly file claims with the insurance company. Patients are responsible for any deductible and co-insurance/copayments that apply. *Payment is expected at the time of service.*

We will not enter into dispute with your insurance company over unpaid or uncovered services. Coverage is an agreement between you and your insurance company.

Insurance may make a contribution towards your care; *we do not anticipate that they will cover 100% of your visits*. We require a photocopy of your insurance card and a photocopy of your driver's license on file in order to direct bill your insurance coverage.

In the event that your insurance company sends payment to you, the patient, for services we have direct billed, it is your responsibility to endorse these payments, along with copies of explanations of benefits, to our office in order to apply them to your account. *Failure to do so constitutes insurance fraud on the part of the patient, and we will take all necessary steps to recover these funds.*

By initialing each paragraph above and providing your signature below, you are agreeing to the above listed policy.

_________________________________ __________________

Signature Date