INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:

Carrier _____

Address_____ City _____

State _____ Zip code _____ Phone _____

Policy ID Number _____ Group _____

Name of the Policy Holder_____ Relationship _____

Address_____ City _____

State _____Zip_____

Date of Birth _____ Social Security number _____ Sex M F

Employer_____ Occupation _____

SECONDARY INSURANCE COMPANY:

Carrier _____

Address_____ City _____

State _____ Zip code _____ Phone _____

Policy ID Number _____ Group _____

Name of the Policy Holder_____ Relationship _____

Address_____ City _____ State _____ Zip _____

Date of Birth _____ Social Security # _____ Sex M F

Employer_____ Occupation _____

WORKMAN'S COMPENSATION INSURANCE:

Carrier

_____

Address_____ City _____

State _____ Zip code _____ Phone _____

Claim Number _____ Case Worker's Name _____

Case Worker's Phone Number _____ Fax _____

Employer at time of injury _____

Address

_____

ASSIGNMENT OF BENEFITS:

Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered. I authorize release of all medical information necessary to process my insurance claims or that is pertinent to my medical care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled to the above named physician or clinic. This agreement will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

Patient _____ Date _____

Responsible Party _____ Date _____