BILLING INFORMATION

PATIENT INFORMATION

Name:_____
Address:_____
City:_____ **State:**_____ **Zip:** _____
Phone: (H):_____ **(W):**_____
(Cell):_____ **Email:**_____
Date of Birth:_____ **Male: Female:** _____
Marital Status: Married:_____ **Single:**_____ **Partnered:**_____
Relationship of Patient to Insured:
Self_____ **Spouse**_____ **Partner Child Other** _____
Patient's Social Security Number: _____
Is patient's condition related to? (Please circle one)
Employment_____ **Auto Accident**_____ **Illness**_____ **Other**_____

PRIMARY HEALTH CARE PROVIDER

Name:_____
Address:_____
City/State/Zip:_____
Phone:_____ **Fax:** _____

HEALTH INSURANCE INFORMATION

Insured (If other than patient)
Name:_____
Date of Birth:_____ **Male** _____ **Female** _____
Address:_____
City:_____ **State:**_____ **Zip:**_____
Phone: (H):_____ **(W):**_____
(Cell):_____ **Email:** _____

Primary Insurance:

Insurance Carrier: _____
Contact:_____
ID#: _____
Group#:_____
Billing Address: _____
City:_____ **State:**_____ **Zip:**_____
Phone:_____ **Fax:** _____

Secondary Insurance:

Insurance Carrier: _____
Contact:_____
ID#: _____
Group#:_____
Billing Address: _____
City:_____ **State:**_____ **Zip:**_____
Phone:_____ **Fax:** _____

WORKERS' COMPENSATION

Employer:_____
Date of Injury: _____
Claim #: _____
Adjuster:_____
Billing Address: _____
City:_____ **State:**_____ **Zip:**_____
Phone:_____ **Fax:** _____

AUTO ACCIDENT (PIP)

Insured:_____
Date of Accident: _____
Insurance carrier: _____
Policy #: _____
Claim #: _____
Adjustor:_____
Billing Address: _____
Phone:_____ **Fax:** _____

ATTORNEY

Name:_____
Address:_____
City/State/Zip:_____
Phone:_____ **Fax:** _____

AUTO ACCIDENT (3rd Party)

Insured:_____
Date of Accident: _____
Insurance carrier: _____
Policy #: _____
Claim #: _____
Adjustor:_____
Billing Address: _____
Phone:_____ **Fax:** _____

ASSIGNMENT OF BENEFITS

My signature below authorizes and directs payment of medical benefits for services billed to my health care provider.

RELEASE OF MEDICAL RECORDS

My signature below authorizes the release of my medical records including intake forms, chart notes, reports, and billing statements to my attorneys, health care providers, and insurance case managers, for the purpose of processing my claims. (I will inform my practitioner immediately upon signing any exclusive Release of Medical Records with my attorney.)

FINANCIAL RESPONSIBILITY

It is my responsibility to pay for all services provided. In the unfortunate event that my insurance company denies payment or makes partial payment, I am responsible for the balance. A 1.5% interest will accrue monthly on any outstanding balance. If you have contracted with my insurance company at a discount rate and the agreed upon fee has been satisfied, the balance will be waived.

Signature:_____ **Date:** _____