Customer Information & Insurance Form

CONTACT INFORMATION

Name: ____ **M / F**
Last First Middle I.

Date of Birth: ____________________ **Email:** ____________________________

Home Phone: (_____) _______________ **Mobile Phone:** (_____) _______________

Address: ______________________________ **City:** __________ **ST:** ___ **Zip:** _____
Apt/Unit #

Other Contact:__________________________ **Phone:** (_____) _______________

PRIMARY INSURANCE

Company: _______________ **Plan/ID #:** _______________ **Group #:** __________

Claims Address: ____________________ **City:** __________ **ST:** ______ **Zip:** _______

Subscriber/Name of Insured: ______________________________ **DOB:** ____________
Last First

Gender: M / F Relationship: Spouse / Other _______________

SECONDARY INSURANCE

Company: _______________ **Plan/ID #:** _______________ **Group #:** __________

Claims Address: ____________________ **City:** __________ **ST:** ___ **Zip:** _____

Subscriber/Name of Insured: ______________________________ **DOB:** _______
Last First

Gender: M / F Relationship: Spouse / Other _______________

DOCTOR INFORMATION

Name: ____
Last First Middle I. MD/ARNP/PA-C/etc.

Address: ______________________________ **City:** ____________ **ST:** ____ **Zip:** _____
Suite #

Phone: (_____) ____________ **Fax:** (_____) ____________ **NPI:** _______________

Primary Diagnosis: ____________________ **ICD.10#** __________ Left / Right / Bilateral

Secondary Diagnosis: ____________________ **ICD.10#** __________ Left / Right / Bilateral

I AGREE TO PAY ALL COSTS, CO-PAYS, DEDUCTIBLES, AND FEES ASSOCIATED WITH MY CLAIM.

I understand that I have 30 days from the statement date to pay by check or credit card. If necessary, I will call to arrange a payment plan. I understand that any balance owed past 30 days will be charged to a credit card on file.

☐ Please send me a statement with any deductible or coinsurance payments I owe.

☐ Please charge any balance to my credit card ☐ Mail receipt ☐ Keep receipt in file

Credit Card # ____ **Exp.** __________ **CVV:**_______
Visa / MasterCard / Discover

Authorizing Person's Signature

I accept full fiscal responsibility for any and all portions of this claim not covered by my insurance. All the information above is correct and true.

X____ **Date:** ____________________