INSURANCE INFORMATION

Name ____
(Last) (First) (M)
Patient Employed by ____

Occupation ____

Business Address____________________________ Business Phone ____________________

In case of emergency who should be notified? ______________________________________

Relationship ____________________________ Phone _______________________________

PRIMARY INSURANCE

Insurance Name ____

Policy/ID/Member # ____

Person responsible for account ____

Relationship to patient _______________DOB _____/_____/_____ SS#______-_____-_______

Address ____

Person responsible employed by ____

Business Address ______________________________ Business Phone _________________

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I have insurance coverage with ___________________________ (Name of Insurance Company) and assign directly to Maria Betancourt, MD all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all medical and laboratory charges whether or not paid by insurance. I hereby authorize Maria Betancourt, MD to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____
(Patient's Signature) (Relationship to Insured/Responsible Party) (Date)