

**INSURANCE INFORMATION**

(Please fill out all of the appropriate information)

**A COPY OF YOUR INSURANCE CARD IS REQUIRED**

**PRIMARY INSURANCE**

Name of Insurance Company: \_\_\_\_\_

Policy Holders Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Policy Holders SS#: \_\_\_\_\_ Sex:  M  F Date of Birth: \_\_\_\_\_

Policy Holders Employer: \_\_\_\_\_

ID/Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Effective date of coverage: \_\_\_\_\_

Do you have a copay?  Yes  No Amount? \_\_\_\_\_ Is this a PPO, POS, or HMO? \_\_\_\_\_

Does your visit require a referral?  Yes  No Authorization Number: \_\_\_\_\_

**SECONDARY INSURANCE**

Name of Insurance Company: \_\_\_\_\_

Policy Holders Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Policy Holders SS#: \_\_\_\_\_ Sex:  M  F Date of Birth: \_\_\_\_\_

Policy Holders Employer: \_\_\_\_\_

ID/Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Effective date of coverage: \_\_\_\_\_

Do you have a copay?  Yes  No Amount? \_\_\_\_\_ Is this a PPO, POS, or HMO? \_\_\_\_\_

Does your visit require a referral?  Yes  No Authorization Number: \_\_\_\_\_

**ACCIDENTS-Auto**

**If your injury is a result of an auto accident, please fill out this section**

Policy Holders Name: \_\_\_\_\_ Date the accident occurred: \_\_\_\_\_

Policy Holders Address: \_\_\_\_\_

Auto Insurance Co. Name: \_\_\_\_\_ Policy #: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Attorney's Name: \_\_\_\_\_ Address: \_\_\_\_\_

**WORKMEN'S COMP** **If your injury is a result of an accident that occurred on the job, please fill out this section**

Employer: \_\_\_\_\_ Contact Name: \_\_\_\_\_

Employers Address: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Was injury reported to employer?  Yes  No

**Payment Policy:**

**HMO, PPO or other managed care patients:** You will be responsible for paying your annual deductible, co-payment and co-insurance for any insurable charges.

**Commercial Patients:** Patients who are covered by private or commercial plans in which our physicians are out-of-network will be held responsible for all of the out-of-network charges accrued. All applicable co-payments will be collected at the time services are rendered.

**IMPORTANT!** Please present your insurance card(s) and your photo ID to the receptionist. The receptionist will make a copy and return them to you promptly.