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)