

Insurance Information

Primary Insurance Co. Information:

Company Name: _____

Address: _____

Insurance # _____

Group # _____

Do you have a Co-pay?
(YES) Amt\$ _____ or (NO)

Secondary Insurance Co. Information:

Company Name: _____

Address: _____

Insurance # _____

Group # _____

Do you have a Co-Pay?
(YES) Amt\$ _____ or (NO)

Policy Holder Information (if not self)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Policy Holder Date of Birth _____

Policy Holder SS# _____

Policy Holder Information (if not self)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Policy Holder Date of Birth _____

Policy Holder SS# _____

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND HEREBY ASSIGN TO DR. VERDI OR DR GOLDBERG ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO SELF OR DEPENDENTS.

I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR ALL OF THE CHARGES FOR ALL OF THE SERVICES RENDERED TO ME OR ANY MEMBER OF MY FAMILY.

ALTHOUGH I HAVE REQUESTED THE DOCTOR TO BILL MY INSURANCE COMPANY ON MY BEHALF, I CLEARLY UNDERSTAND THAT IF A BILL IS NOT PAID BY MY INSURANCE WITHIN A TIMELY MANNER, I AGREE TO MAKE ARRANGEMENTS FOR PROMPT PAYMENT TO DR. VERDI OR DR. GOLDBERG.

I AGREE TO HAVE A VALID REFERRAL (IT IS POLICYHOLDER'S RESPONSIBILITY TO KNOW IF INSURANCE REQUIRES REFERRAL) FOR VISIT AND ANYTIME INSURANCE CHANGES.

PLEASE NOTE: IF YOU HAVE NO INSURANCE YOU WILL BE RESPONSIBLE FOR PAYMENT AT TIME OF SERVICES.

Patient's Signature: _____

Guardian's Signature:
(or other responsible party) _____

Today's Date: _____