INSURANCE INFORMATION

Health Insurance (Must be completed, even if Work Comp or Auto being billed first)

Insurance Company: _____ ID #: _____ Group #: _____

Full Name of Guarantor/Responsible party: _____

Relationship to Patient _____ Birth Date _____ Soc. Sec. #: _____

Address (If different than patient's): _____

City: _____ State: _____ Zip: _____ Phone: _____

Person Responsible Employed by: _____ Occupation: _____

Business Address: _____ Zip: _____ Phone: _____

ADDITIONAL INSURANCE: Is patient covered by additional insurance? ___ Yes ___ No

Insurance Company: _____

ID #: _____ Group #: _____

Subscriber's Full Name: _____

Relationship to Patient: _____ Birth Date: _____ Soc. Sec. #: _____

Address (If different than patient's): _____

City: _____ State: _____ Zip: _____ Phone: _____

Subscriber Employed by: _____ Business Phone: _____

Accident Information: **_____ Work Comp _____ Auto _____Other Date of Injury: _____**

**** PLEASE NOTE: If all workmen's comp/auto info is not available, we will set up the billing as SELF-PAY until all information is received by our office.**

Work Comp or Auto (If applicable) Policy or Claim Number: _____

Insurance Company: _____ Phone Number: _____

Address: _____ Contact: _____

Employer: _____ Phone Number: _____

Address: _____ Contact: _____

Assignment and release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assigned directly to Hand, Microsurgery and Reconstructive Orthopaedics, LLP, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature Relationship Date