

INSURANCE BILLING INFORMATION

CLIENT INFORMATION

Full Name: _____ Birthdate: _____
Address: _____ City/State/Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ SSN: _____
Relationship Status: _____ Primary Care Physician: _____

PRIMARY INSURANCE

Name of Insurance: _____ Phone: _____
Claims Address: _____ Email/Web: _____
Subscriber Number: _____ Group Number: _____
Insured Holders Info (if other than self)
Name: _____ Birthdate: _____
Address: _____ City/State/Zip: _____
SSN: _____ Relationship to Insured: _____

SECONDARY INSURANCE (If Applicable)

Name of Insurance: _____ Phone: _____
Claims Address: _____ Email/Web: _____
Subscriber Number: _____ Group Number: _____
Insured Holders Info (if other than self)
Name: _____ Birthdate: _____
Address: _____ City/State/Zip: _____
SSN: _____ Relationship to Insured: _____

ASSIGNMENT OF BENEFITS

I hereby assign to Roxanne George any insurance or other third-part benefits available for health care services provided to me. I understand that Roxanne George has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Roxanne George, I agree to forward to Roxanne George all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

How will you pay for this visit today? Cash _____ Check _____ Other _____