Primary Insurance Information

Relationship to the Insured (Mark One): Self _________ Spouse _______ Child _______ Other ________

Date of birth of the Insured: ________________________

Name of Insured: ______________________________ Employer: ____________________________

Group number: ____________________

Member ID: _______________________

Insurance Company: ____________________

Address of Insurance Company: ____

Secondary Insurance Information

Relationship to the Insured (Mark One): Self _________ Spouse _______ Child _______ Other ________

Date of birth of the Insured: ________________________

Name of Insured: ______________________________ Employer: ____________________________

Group number: ____________________

Member ID: _______________________

Insurance Company: ____________________

Address of Insurance Company: ____

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1.5% late charge (18% APR) may be added to my account. If required, I understand a check of my credit history or processing to collections may be made.

I understand that 48 business hours is required for cancellation or rescheduling of appointments. I understand that a cancellation fee or deposit may be applied for broken appointments.

Patient's signature: ____

Date: ____