

BILLING INFORMATION

Provider Name _____

Patient Name _____ Date _____

Date of Injury _____ Insurance ID# _____

A. Patient Information

Address _____

City _____ State _____ Zip _____

Phone: Home _____
Work _____ Cell/Pgr _____

Date of Birth _____

Male Female

Marital Status: Single Married Partnered

Relationship of Patient to Insured:

Self Spouse Partner Child Other

Employed Student Part-time Full-time

Employer's Name or School Name: _____

Phone _____ Fax _____

Is patient's condition related to:

Employment Yes No

Auto Accident Yes No

If Auto Accident, in what state? _____

Other Accident Yes No

Illness Yes No

Primary Health Care Provider

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Attorney

Has an attorney been consulted? Yes No

Retained? Yes No

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

B. Insured (if other than patient)

Name _____

Insurance ID# _____

Date of Birth _____

Male Female

Address _____

City _____ State _____ Zip _____

Phone: Home _____

Work _____ Cell/Pgr _____

Employer's Name or School Name: _____

Phone _____ Fax _____

Signature _____ Date _____

C. Primary Insurance Coverage

Insurance Carrier _____

Contact _____

Group Number _____

Plan # or Name _____

Billing Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

D. Secondary Insurance Coverage

Insured _____

Insurance ID# _____

Date of Birth _____

Male Female

Address _____

City _____ State _____ Zip _____

Phone: Home _____

Work _____ Cell/Pgr _____

Employer's Name or School Name: _____

Phone _____ Fax _____

Insurance Carrier _____

Contact _____

Group Number _____

Plan # or Name _____

Billing Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

E. Assignment of Benefits

My signature below authorizes and directs payment of medical benefits for services billed to my health care provider.

F. Release of Medical Records

My signature below authorizes the release of my medical records including intake forms, chart notes, reports, and billing statements to my attorneys, health care providers, and insurance case managers, for the purpose of processing my claims. (I will inform my practitioner immediately upon signing any exclusive Release of Medical Records with my attorney.)

G. Financial Responsibility

It is my responsibility to pay for all services provided. In the unfortunate event that my insurance company denies payment or makes a partial payment, I am responsible for the balance. If you have contracted with my insurance company at a discount rate and the agreed-upon fee has been satisfied, the balance will be waived.