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## INSURANCE INFORMATION

Patient's Name (Please Print): \_\_\_\_\_

Patient's Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Social Security#: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Insurance ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Number of visits per year: \_\_\_\_\_

Do you have a deductible?  Yes  No Amount of deductible: \$ \_\_\_\_\_

Amount of co-pay: \$ \_\_\_\_\_ or percent of client responsibility \_\_\_\_\_

Is referral/prescription required?  Yes  No (If yes, please hand it in immediately.)

Is pre-Authorization required?  Yes  No

Credit card number (MasterCard or Visa): \_\_\_\_\_

Exp. Date: \_\_\_\_\_ Security Code: \_\_\_\_\_ (three or four digit code in front or back of card)

**Credit Card info. will not be used unless payment is not made.**

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical service, or as the responsible part for minor patients. Your signature verifies that you have read the above statement and understand your responsibilities and agree to these terms.

Date: \_\_\_\_\_

Responsible Party Name (please print): \_\_\_\_\_