

Patient Financial Information Sheet

I understand that payment in full is due at time of service unless other arrangements have been made.

Name of Patient: _____ DOB _____

Name of Insured: _____ DOB _____

If No Insurance Card is Available please supply the Insurance Carrier and ID #

Name of Primary Health Insurance Carrier: _____

ID#: _____ Policy #: _____

Name of Secondary Health Insurance Carrier: _____

ID#: _____ Policy #: _____

Name of Vision Insurance Carrier: _____

ID#: _____ Policy #: _____

Insurance Card Copied: Yes No No Card

Authorization and Release:

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I authorize the release of any information including the diagnosis and the records of any treatment or examinations rendered to me or my child to: _____

Signature of patient or parent if minor

Date

HIPAA Privacy Practice acknowledgement

I have received or was offered and declined a notice of privacy practices.

Signature: _____ **Date:** _____