

crafted touch

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Private Health Insurance Information Form

Patient Name _____ Date _____

Parent Name _____

Address _____ City _____ State _____ Zip _____

Home# _() _____ Work # _() _____ Cell# _() _____

Patient Date of Birth _____ Date of Injury _____ Doctor _____

Insurance Carrier _____ Phone# _____

Address _____ City _____ State _____ Zip _____

Policy# _____ ID # _____ Group/Plan # _____

Plan or Program name _____

Name of Insured _____ Insured's Employer _____

contact information is same as above Phone# _____

Address _____ City _____ State _____ Zip _____

Patient's relationship to Insured: self spouse/partner child

Insured's Date of Birth _____ Insured's Sex: F M

Please read and sign below:

Once insurance coverage has been verified, we will be glad to bill directly to and accept payment from the insurance company. It should be understood that all services are charged to you, the patient, who is legally responsible for the payment. Patient agrees to pay all collection costs including, but not limited to reasonable attorney fees, late charges and litigation costs in the event of any breach, including failure to timely make any required payments.

My practice policies include full charge for any missed appointments, and a half-rate fee for late cancellations (\$40-60/session – depending on the duration). Cancellations within 24 hours are considered 'late,' such that I often cannot fill that appointment time. (Exceptions may be made for emergencies or sudden illness.) I hope this policy will be fair to all involved, and give me time to see as many people as possible.

Patient/Parent/Guardian:

I hereby authorize the release of my medical records to the above insurance company for the purpose of payment for my medical bills incurred in this office. I agree to the fee policies above, and authorize the insurance company or attorney to remit payment directly to this office.

Signature: _____ Date: _____

Questions? Please contact: Ask Us! Billing and Collections – 206-523-0515