Insurance Information Sheet

(Please Print)

Insurance Information
(Please Give Insurance Card(s) to Receptionist at Registration)

Primary Insurance_____ Policy No._____Group No._____

Subscriber's Name_____ Relationship to Patient _____

Subscriber's Employer _____ Effective Date_____Expiration Date_____

Secondary Insurance _____ Policy No. _____Group No._____

Subscriber's Name _____ Relationship to Patient _____

Subscriber's Employer _____ Effective Date_____ Expiration Date_____

Please read and sign

CONSENT FOR HEALTHCARE SERVICES:

I hereby, authorize my physician or clinic staff to provide treatment, maintenance, care, and test diagnostic procedures, x-rays surgical and medical treatments as may be necessary for the preservation or protection of my health, safety and well being. I understand that no guarantees have been given as to the effectiveness or outcome of any treatment or procedure rendered. I intelligently, voluntarily and freely give my consent or warrant that I am legally authorized to give consent on behalf of the patient.

AUTHORIZATION TO RELEASE INFORMATION:

I authorize my physician and/or clinic staff to release medical records, related medical information and charge information for my outpatient/clinic visit for the purpose of further medical treatment and determining insurance coverage and medical payment owed to clinic/hospital charges, including but not limited hospital or medical service companies, insurance companies, worker's compensation earners, or welfare funds. I certify that the information given by me in applying for payment under title XVIII and XIX of the Social Security Act is correct. I authorize any holder of medical information given by me to release to the Social Security Administration or its intermediaries or the Medicaid agency or its intermediaries any information needed for the Medicare or Medicaid claim. I consent to the release of information including psychiatric drug, alcohol and substance abuse records. I consent to the release of information of any specialist in the event my physician refers me.

ASSIGNMENT OF BENEFTIS (if covered by insurance):

I direct that my insurance company pay the benefits for this treatment directly to the clinic. I assign to the clinic/hospital for the purpose of security, any right I may have to receive such payment directly from the insurance company, and hereby revoke any prior authorizations which I may have given to the contrary. I agree to cooperate fully with the clinics efforts to obtain payment under such policy and will execute any additional documents my insurance company may require in order to process the clinics claim. In the event of any overpayment of insurance benefits, (as where two policies are subject to a coordination of benefits) I authorize the clinic to refund to the company making such overpayment

FINANCIAL.RESPONSIBILITY:

I understand that by signing below I AGREE TO PAY THE CLINIC BILL for the services rendered, whether or not I am the patient. I agree that I will pay this bill in full whether or not charges are or should have been covered by insurance. I have been advised that the clinic does not extend credit and that payment is due in full at time of service. I agree that if this account is not paid when due, and if the clinic refer it to an attorney for collection, I will pay all costs of collection including interest, and a reasonable attorney's fee (even if suit is not filed). I hereby waive all rights of exemption which are available to me under the laws of Alabama or of the United States.

Signature of Patient or Patients Guardian_____ Date _____