INSURANCE AND PAYMENT INFORMATION

1. PATIENT INFORMATION

Patient Name _____ Date _____ SSN# _____
Sex: □Male □Female D.O.B. _____ E-mail _____
Address _____ City _____ State _____ ZIP _____
Phone: (____) _____ Work (___)_____ Cell (___)_____
Employer _____
In case of emergency, contact _____ Phone _____
Who may we thank for referring you to our office?_____

2. ACCIDENT INFORMATION

Is your condition due to an accident/injury? ___Yes ___No Date of accident _____
Type of accident __Auto __Work __Other _____

3. RESPONSIBLE PARTY

Who is responsible for this account? _____
Relationship to patient _____ Phone _____
How do you plan on paying for your care?

□ Payment at time of service. We will provide you with a discount off our regular fee schedule.
Note: By law, we must charge our regular fee schedule if not paid at time of service.
□ Insurance Policy Coverage

4. INSURANCE INFORMATION

Primary Insurance Information
Insurance Co.: _____
Policy Holder: _____
Policy Holder's Birth date: _____
Policy Holder's Employer _____
Relationship to Policy Holder: Check One
□ Self □ Spouse □ Child □ Other
Policy Number _____
Group Number _____

Secondary Insurance Information
Insurance Co. _____
Policy Holder: _____
Policy Holder's Birth date: _____
Policy Holder's Employer _____
Relationship to Policy Holder: Check One
□ Self □ Spouse □ Child □ Other
Policy Number _____
Group Number _____

Insurance Policy Coverage – Please read the following policies:

1. We may accept assignment of insurance benefits. However, the balance is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. It is in your best interest to be familiar with your policy.
2. As a courtesy to you, we submit claims to your insurance company. Your insurance company may require additional information form you before they will pay or deny a claim. It is your responsibility to provide this information promptly.
3. All deductibles and co-pays are due at the time of service.
4. Any insurance payment mailed to you should be brought to the office, along with the attached insurance statements within three days. Any monies kept without our consent or approval will be considered theft.
5. Our practice is committed to providing the highest quality, affordable care for our patients and we charge what is usual and customary for our area. You are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.
6. Our practice only performs those services which are medically necessary. You are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.

5. ASSIGNMENT OF BENEFITS

I, the undersigned (or my dependant) certify that I have insurance coverage and assign directly to Oak Creek Relief & Wellness, S.C. all insurance benefits, if any, otherwise payable to me for services rendered. **I UNDERSTAND THAT I AM ULTIMATELY FINANCIALLY RESPONSIBLE FOR ALL FEES NOT COVERED BY MY INSURANCE POLICY**. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____Relationship _____ Date _____