INSURANCE FORM

Name: _____ Phone: ( )_____

Work phone: ( )_____Cell: ( )_____Email:_____

Address:_____ City: _____ ST:___ Zip:_____

Date of birth: _____ SS#_____ Referred by: _____

Primary Care Physician (PCP): _____ PCP Phone: ( )_____

Emergency Contact Person: _____ Phone: ( )_____

MEDICAL INSURANCE INFORMATION

Insurance Company: _____ Plan Name: _____

Insurance Address: _____ City:_____

ST:____ Zip:_____ Insurance Phone: ( )_____

Name of Policy Holder: _____Relation to patient_____

Policy/ID#_____ Group:_____

Pre-authorization number:_____ Copay amount per visit:_____

FINANCIAL AGREEMENT

I FULLY UNDERSTAND AND AGREE THAT HEALTH INSURANCE POLICIES ARE ARRANGEMENTS BETWEEN INSURANCE CARRIER(S) AND MYSELF. FURTHERMORE, I UNDERSTAND THAT DANIEL MOLLOD, MD., WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTIONS FROM MY INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO DANIEL MOLLOD, MD., WILL BE CREDITED TO MY ACCOUNT UPON RECEIPT. I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE MY PERSONAL RESPONSIBILITY FOR PAYMENT. I ALSO UNDERSTAND THAT WHEN RELEASED FROM CARE FOR THIS PRESENT CONDITION, ANY REMAINING FEES FOR PROFESSIONAL SERVICES ARE DUE WITHIN 30 DAYS.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM ONLY. I ALSO REQUEST PAYMENT OF INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT.

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO DANIEL MOLLOD, MD., FOR SERVICES DESCRIBED.

I HAVE READ AND AGREED TO THE ABOVE AND ACKNOWLEDGE THAT THE INFORMATION GIVEN ON THESE FORMS IS TRUE.

_____ _____

RESPONSIBLE PARTY SIGNATURE DATE