**BILLING INTAKE INFORMATION FORM**

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| PATIENT’S NAME; | DATE: |
| ADDRESS: | CITY: STATE: ZIP: |
| TELEPHONE NUMBER: WORK: | HOME: |
| SOCIAL SECURITY NUMBER: \_\_\_ | DATE OF BIRTH: |
| ARE YOU EMPLOYED? YES: | NO: \_\_\_\_\_\_ |

IF YES, NAME AND ADDRESS OF YOUR EMPLOYER:

DO YOU HAVE INSURANCE COVERAGE? YES: NO:

IF YES, NAME AND ADDRESS OF INSURANCE COMPANY: NAME OF POLICYHODER: DATE OF BIRTH: RELATIONSHIP TO PATIENT: GROUP NUMBER:

IDENTIFICATION NUMBER:

ARE YOU COVERED BY A SECOND INSURANCE COMPANY? YES: NO: IF YES, NAME AND ADDRESS OF SECONDARY INSURANCE COMPAY: NAME OF POLICYHOLDER: DATE OF BIRTH: RELATIONSHIP TO PATIENT: GROUP NUMBER:

IDENTIFICATION NUMBER:

WHO REFERRED YOU TO THIS OFFICE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IN ORDER TO SECURE PAYMENT FOR MY TREATMENT THROUGH MY

INSURANCE COMPANY, I AUTHORIZE  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** TO

COOPERATE WITH MY INSURANCE COMPANY’S CLAIMS AND MANAGED

CARE PROCEDURES, INCLUDING RELEASING SUFFICIENT CLINICAL

INFORMATION (FOR EXAMPLE, DIAGNOSIS, SYMPTOMS, AND TREATMENT

PLANS) TO ANSWER THEIR SPECIFIC QUESTIONS. I UNDERSTAND THE

INSURANCE/MANAGED CARE COMPANY IS OBLIGATED TO MAINTAIN THIS

INFORMATION CONFIDENTIALLY. I AUTHORIZE THE AFOREMENTIONED

INSURANCE COMPANY TO MAKE PAYMENT DIRECTLY TO **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I UNDERSTAND THAT I AM FINANCIALLY

RESPONSIBLE FOR THE CHARGES NOT COVERED BY MY INSURANCE AND THAT THE ENTIRE BILL IS MY RESPONSIBILITY REGARDLESS OF MY INSURANCE COVERAGE.

SIGNATURE: DATE

SIGNATURE OF RESPONSIBLE PARTY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (If patient is under 18 years old)