



INSURANCE FORM

Patient Name (Last, First): _____ DOB: _____ Gender: M / F

Is visit related to accident? Yes / No If so, Date/Place: _____ Was accident work related? Y / N

Worker's Compensation Insurance

Carrier/Address: _____

Claim#: _____ Attorney Name: _____ Phone: _____

Attorney Address: _____ Fax: _____

Primary Health Insurance

Insured's Name (May be different than patient name) (Last, First): _____

Relationship to Patient: _____ DOB: _____ Gender: M / F

Address: _____ City: _____ State: _____ Zip: _____

Tel/Home: _____ Tel/Cell: _____ Tel/Work: _____

Employer Name/Address: _____

Insurance Carrier/Address: _____ Tel: _____

Subscriber ID#: _____ Group #: _____

Additional Insurance (If Applicable)

Insured's Name (May be different than patient name) (Last, First): _____

Relationship to Patient: _____ DOB: _____ Gender: M / F

Address: _____ City: _____ State: _____ Zip: _____

Tel/Home: _____ Tel/Cell: _____ Tel/Work: _____

Employer Name/Address: _____

Insurance Carrier/Address: _____ Tel: _____

Subscriber ID#: _____ Group #: _____

Assignment of Benefits and Release

I hereby authorize payment directly to Healthpointe Enterprises, Inc. for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges if insurance does not cover them. I authorize Healthpointe Enterprises, Inc. to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Submission to insurance companies is not a guarantee of payment. I also understand that the full fee will be charged if I miss an appointment giving less than 24 hours notice. I understand that this missed appointment fee will not be covered by insurance and that I will be responsible for payment.

Signature of Patient/Legal Guardian/Responsible Party

Relationship/Authority

Date