

For Provider Use ONLY:

Provider Name:

Diagnosis Code:

Referring Provider:

Authorization #:

COMPLETE AND ACCURATE INFORMATION IS REQUIRED

PATIENT

Patient Name _____ SS# _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Male _____ Female _____ GI _____ Marital Status _____

Phone: Cell Home Work _____ Email _____

RESPONSIBLE PARTY

Name & address of person responsible for any balance not covered by insurance:

Same as Patient Other

Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

INSURANCE Include copy of front & back of insurance card

Primary Insurance _____

Insurance Address _____ Phone _____

City _____ State _____ Zip _____

Subscriber #: _____ Group#: _____

Secondary Insurance _____

Insurance Address _____ Phone _____

City _____ State _____ Zip _____

Subscriber #: _____ Group#: _____

SUBSCRIBER

Same as Patient Same as Responsible Party Other

Subscriber Name _____ Date of Birth _____ SS# _____

Patient Relationship to subscriber: Self _____ Spouse _____ Child _____ Other (specify) _____

Employer _____ Phone _____

INSURANCE AUTHORIZATION AND ASSIGNMENT: I hereby authorize the Provider of service to furnish information to insurance carriers concerning my condition and treatment. I hereby assign to the provider all payments for medical services rendered to my dependents or myself. I hereby authorize the Provider to share my information with any third party service for which they have a fully executed HIPAA Business Associate Agreement. I UNDERSTAND I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. I understand I am responsible for any session no-showed or canceled with less than 24 hours notice that will result in a \$175 no-show fee.

Signature _____ **Date** _____