

RESPONSIBLE PARTY INFORMATION FORM

Patient Name: _____

Mother's Name: _____

Address: _____

Contact #: (____)____-_____

Father's Name: _____

Address: _____

Contact #: (____)____-_____

Primary Insurance Co. _____ **I.D.#** _____

Subscriber's Name _____ **Group#** _____

Subscriber's I.D.# _____

Social Security # _____

Date of Birth _____

Relationship to Patient _____

Subscriber Address: _____

Do you need a referral? _____

Amount of Copay? _____

Secondary Insurance Co. _____ **I.D.#** _____

Subscriber's Name _____ **Group#** _____

Subscriber's I.D.# _____

Social Security # _____

Date of Birth _____

Relationship to Patient _____

Subscriber Address: _____

Do you need a referral? _____

Amount of Copay? _____

FINANCIAL ASSIGNMENT AND AGREEMENT:

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, coinsurance, or any other balance not paid by your insurance. We request that copays for office visits be paid at the conclusion of each visit unless you are covered by Medicare.**

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Patient/Guardian Signature _____ **Date** _____

Updated on _____ **Initials** _____

Updated on _____ **Initials** _____