Health Insurance Verification Form

Client Information			
First Name	Last Name	Date of Birth	Gender
Address	City	State	Zip Code
Cell Phone Number	Email Address	Do you have a legal guardian? Yes ○ No ●	
		Race	

Client Insurance Information			
Primary Insurance Company		Policy Number	Group Number
Subscriber's First Name	Subscriber's Last Name	Date of Birth	
Subscriber's Relationship to Patient			
Address	City	State	Zip Code
Is this a Medicaid or Medicare Policy? ○ Yes ● No			
Secondary Insurance Company		Policy Number	Group Number
Subscriber's First Name	Subscriber's Last Name	Date of Birth	
Subscriber's Relationship to Patient			
Address	City	State	Zip Code
Is this a Medicaid or Medicare Policy? ○ Yes ● No			

Authorization to Release Information

I authorize the release of the above provided information and any medical information necessary to: 1) provide for adequate professional coverage in the absence of the primary doctor; 2) to verify insurance coverage; 3) to file a claim for insurance benefits related to professional services rendered.

Client/Financially Responsible Party Signature: _____ Date: _____

Emergency Contact Information:

Name: _____ Relationship: _____ Phone Number: _____

A member of our finance team will be contacting you to discuss the details of your or your loved one's benefits, cost of treatment, and answer any questions you may have.

If you would like to designate someone other than yourself to be financially responsible, please provide their information below:

Name of Financially Responsible Party: _____ Relationship to Client: _____

Cell Phone Number: _____ Email Address: _____