

About your Insurance:

Insurance Company: _____

Policy Holder: _____

DOB: _____
Policy Number: _____

Medicare Number: _____
Group Number: _____
Medical Assistance Number: _____

Secondary Insurance Company (if applicable):

Policy Holder: _____
DOB: _____
Policy Number: _____

Person Responsible for Payment if Patient is Not Insured:

DOB: _____ Phone: _____
Address: _____
City: _____ State: ____ Zip: _____

Our policies:

Note: All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. Patient is responsible for all balances owed after University Services has processed all services rendered to the appropriate insurance carrier. All patient co-pays/deductible, if applicable, are due at time of service.

Email Policy: Your email address will not be sold to any third parties. University Services will use your email for appointment reminders, educational newsletters, and notify you of events at our centers.

Please check the appropriate boxes:

You can use my email address for appointment reminders: Yes No

You can use my email address for newsletters and events: Yes No

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize University Services to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to University Services all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance.

I authorize University Services to release the results of my testing to the physician(s) listed on this form.

Date: _____ Signature: X _____