INSURANCE INFORMATION

Please present **ALL** Insurance cards and Referrals along with picture I.D. at check-in

Patient Name: ______________________________ DOB: ___________

Insurance Company: ______________________________

Policy Holder: ________________________ SSN: _________________ DOB: _____

Relationship to Patient: __________________ Contact Phone Number: ____________

OFFICE POLICY ON PAYMENT

All questions concerning fees should be asked prior to service. I authorize my insurance company to make payments for all medical services directly to Family Arthritis Center. I agree that any balance will be paid by me, and that I am responsible for any collections fees incurred.

Transfer of medical information; I authorize Family Arthritis Center to release any information necessary to secure payment for services provided, or to further my medical care.

Patient Signature: ______________________________________ Date: ____________