

Family Medicine Associates of Midland, P.C.

Different insurance companies require different information – this form must be complete in order to file your claim:

PLEASE PRINT:

Patient's Name _____ Birth date _____ Age _____ Soc. Sec. Number _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Marital Status: Single Married Legally Separated Divorced Widowed
Patient's Address: _____

Employer: _____ Phone: _____
Address: _____

Emergency Contact Name: _____ Phone Number: _____
Address: _____ Relationship: _____

Referred to our office by: _____

If you have insurance coverage, who's name is the insurance under? Yours Spouse Your Father/Mother

Name of the insured subscriber: _____ DOB: _____ SS# _____

Address of subscriber: _____

Home Phone Number of Subscriber: _____ Work Phone # of Subscriber _____

Subscriber's Employer: _____

Address: _____

Insurance Company Name: _____ Billing Address: _____

Contract Number: _____ Group Number: _____ Service Code: _____ Effective Date _____

Secondary Insurance Company: _____ Phone Number: _____

Billing Address: _____

Secondary Insurance Subscriber's Name: _____ DOB: _____ SS# _____

Employer: _____ Address: _____

Your relationship to secondary subscriber: Spouse Child Other: _____

Contract # _____ Group# _____ Service Code _____ Effective Date _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to Family Medicine Associates of Midland, P.C. of the Surgical and/or Medical Benefits, if any, otherwise payable to me for those services. I understand the provider's charge may exceed the private insurance carrier payment, and if greater than such payment, I will be responsible for that amount. I will also be responsible for any charges that are not covered benefits of my insurance plan as well as co-payments and/or deductibles.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Family Medicine Associates of Midland, P.C. to release my information required in the course of my examination for treatment, payment and/or health care operations. This includes any AIDS/HIV, Drug Alcohol, or Psychological testing/results that may have been performed. A photocopy of this assignment and release of information is to be considered as valid as the original and will remain in effect until revoked by me in writing.

Patient Signature (parent/guardian if minor)

Date