



\*\*\*\* PAYMENT IS REQUIRED AT TIME OF SERVICE \*\*\*\*

Unless *PRIOR* Arrangement are made

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**Billing Information & Responsible Party**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip Code \_\_\_\_\_

\_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

PRIMARY Insurance: \_\_\_\_\_ Group # \_\_\_\_\_

ID# \_\_\_\_\_

Address: \_\_\_\_\_ Relation: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

SECONDARY Insurance: \_\_\_\_\_ Group# \_\_\_\_\_ ID# \_\_\_\_\_

Address: \_\_\_\_\_ Relation: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Referral: Yes \_\_\_ No \_\_\_

ACCOUNT # \_\_\_\_\_ Date: \_\_\_\_\_ Patient Signature \_\_\_\_\_ j3/08