Insurance Information

Patient Name: _____Today's Date: _____
[Primary Insurance]
Name of Insurance Company: _____
Insured's Name: _____
Group Number: _____Policy ID Number: _____
[Secondary Insurance]
Name of Insurance Company: _____
Insured's Name: _____
Group Number: _____Policy ID Number: _____

Did your injury happen on the job? Yes No
If yes, on what date did the injury occur?_____
Did you report the accident to your employer? Yes No
Is this visit to be billed to an auto or worker's compensation policy? Yes No
If yes, please list information below:
Name of Insurance Carrier:_____
Contact Person: _____Phone ( )_____
Mailing Address:_____
City, State, Zip: _____
Insured's Name: _____
Claim Number: _____Date of Injury:_____

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay, and non-covered service amounts. See our complete financial policy for details.

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO PHYSICIAN:

I hereby authorize Mark C. Stewart, M.D. to release to my insurance company any information acquired in the course of my treatment. This authorization also allows the release of any information to another physician in the event it becomes necessary for you to be referred to another physician. It also allows the release of information to your referring physician, if you were referred by another doctor. This release specifically includes information with respect to communicable diseases or infections, including HIV virus (i.e. AIDS virus).

I further hereby authorize my insurance company to pay directly to Mark C. Stewart, M.D. surgical or medical benefits, if any, otherwise payable to me for services rendered. I understand that amounts deemed by my insurance company to be beyond what they consider "unusual, customary, and/or reasonable charges" for said services will be paid be me. I also understand that I will be liable for any deductible and/or co-payment amounts indicated by my insurance company.

This authorization will remain in effect until revoked, in writing, by me with a copy of the revocation given to Mark C, Stewart, M.D.

Signature of Patient/Responsible Party: _____Date: _____