

Insurance Information

Insurance Company:	_____	Phone #:	_____
Address:	_____		
	Street/PO Box	City	State Zip
Group #:	_____		
Insured's Names:	_____		
Insured's Employer:	_____		
Insured's SS#:	_____	Birthdate:	__ / __ / __
Relationship to Patient:	_____		
Is patient covered by additional insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you want your insurance company to pay Drs. Psota directly?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
ASSIGNMENT AND RELEASE			
I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Drs. Alan/Jennifer Psota all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.			
_____ Responsible Party Signature			

Copy Insurance Card Below