



Patient Authorization Form

Patient Name:
Reason for Visit:
Mailing Address:
Street Address (if different than mailing):

Home Phone: _____ **Work Phone:** _____ **Leave a Message:** [gu] P q

Date of Birth: _____ **Social Security Number:** _____
Marital Status: _____ **Email Address:** _____

Primary Insurance: _____ **Subscriber Name:** _____
Address: _____ **Subscriber ID:** _____
Phone Number: _____ **Date Of Birth:** _____
Group Name: _____ **Group Number:** _____

Secondary Insurance: _____ **Subscriber Name:** _____
Address: _____ **Subscriber ID:** _____
Phone Number: _____ **Date Of Birth:** _____
Medigap? [gu] P q **Supplemental?** [gu] P q **Group Number:** _____

Employer Name: _____ **Employer Phone Number:** _____
Address: _____

Emergency Contact Name: _____ **Emergency Contact Phone Number:** _____
Pharmacy Name: _____ **Pharmacy Number:** _____

HIPPA information received: [gu] P q initial - _____

I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. Initial - _____

I understand that I am financially responsible for paying any unpaid balance not covered by my insurance and any additional fees incurred as the result of Collection Agency involvement. I also understand that this authorization is valid for one year from the date below unless changes occur at which time I will notify this office. Initial - _____

Signature of Responsible Party: _____ Date: _____

Print Name of Responsible Party (if different from Patient): _____