INSURANCE INFORMATION

(Please present your Driver's License or picture ID

Along with your Insurance cards to the Receptionist)

Person Financially Responsible_____DOB_____Phone_____

Address_____

Employer_____Occupation:_____Work Phone_____

Employer Address_____

Primary Insurance_____Group#_____Policy#_____

Subscriber's Name_____DOB_____SS#_____

Relationship to Patient_____Copayment_____

Secondary Insurance_____Group#_____Policy#_____

Subscriber's Name_____DOB_____SS#_____

Relationship to Patient_____Copayment_____

We will make copies and or scan your insurance cards as a courtesy we will file your insurance. If you have more than two insurances, please let us know.

The above information is true to the best of my knowledge. I have read and understand the Notice of Privacy Practice presented to me at the front desk. I authorize my insurance benefits to be paid directly to McRichland PLLC. I understand that I am financially responsible for any balance my insurance does not pay or denies for any reason. I also authorize McRichland PLLC or my insurance company to release any information required to process my claims. I understand that authorizations will be obtained but are not a guarantee of payment. I understand that Medical Transcriptionist may have to access to my medical records.

Patient Signature_____**Today's Date:**_____