

Today's Date \_\_\_\_\_

Patient Information					
Name (Last, First, MI)	Social Security	Age	Birthdate	Sex	Home Phone
Mailing Address	City	State	Zip Code	Marital Status	
Employer	City	State	Zip Code	Work Phone	

Responsible Party Information					
Name (Last, First, MI)	Social Security	Age	Birthdate	Sex	Home Phone
Mailing Address	City	State	Zip Code	Marital Status	
Employer	City	State	Zip Code	Work Phone	

Insurance Information			
Primary Insurance Company	Subscriber's Name, Birthdate, SSN	Relationship	Policy Number/Group #
Secondary Insurance Company	Subscriber's Name, Birthdate, SSN	Relationship	Policy Number/Group #
Tertiary Insurance Company	Subscriber's Name, Birthdate, SSN	Relationship	Policy Number/Group #

Emergency Contact Information		
Contact Name	Relationship	Phone Number (s)

**Patient Release:**

I certify the information I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider.

I permit a copy of this release to be used in place of the original.

Signature: \_\_\_\_\_  
 (Signature of insured or responsible party)

Date: \_\_\_\_\_

**ASSIGNMENT OF BENEFITS & RELEASE OF  
INFORMATION AUTHORIZATION**

1. I AUTHORIZE PL PHYSICIANS TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SERVICES RENDERED.
2. I CERTIFY THAT THE INFORMATION I HAVE REPORTED IN REGARD TO MY INSURANCE COVERAGE IS CORRECT.
3. I AUTHORIZE PAYMENT OF ALL MEDICAL INSURANCE BENEFITS WHICH ARE PAYABLE UNDER THE TERMS OF THE INSURANCE POLICY'S COVERING (NAME OF PATIENT(S)) \_\_\_\_\_ TO BE PAID DIRECTLY TO PL PHYSICIANS FOR SERVICES RENDERED. I FURTHER AUTHORIZE THE RELEASE OF ANY INFORMATION NEEDED FOR PROCESSING ANY INSURANCE CLAIMS. A COPY OF THIS ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION AUTHORIZATION MAY BE USED IN THE PLACE OF THE ORIGINAL.
4. THIS AUTHORIZATION MAY BE REVOKED IN WRITING BY EITHER ME OR MY INSURANCE COMPANY AT ANY TIME.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

**PAYMENT RESPONSIBILITY**

1. I UNDERSTAND THAT COPAYS ARE REQUIRED AT THE TIME OF THE VISIT. I FURTHER UNDERSTAND THAT I AM RESPONSIBLE FOR ANY BALANCE NOT PAID BY INSURANCE.
2. I FURTHER AGREE, IN THE EVENT OF NON-PAYMENT, TO BEAR THE COST OF COLLECTION, AND/OR COURT COSTS AND REASONABLE LEGAL FEES SHOULD THIS BE REQUIRED.

SIGNATURE OF RESPONSIBLE PERSON: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_ DATE: \_\_\_\_\_