

## Patient Insurance Information

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Primary Insurance:** \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Insured social security # \_\_\_\_\_ Co-Pay Amount \$ \_\_\_\_\_

Podiatry Coverage: YES / NO % \_\_\_\_\_ Orthotics: YES / NO % \_\_\_\_\_

Deductible: \$ \_\_\_\_\_ Has it been met? YES / NO How Much? \$ \_\_\_\_\_

If HMO policy is this consult authorized by insurance? YES / NO

**Secondary Insurance:** \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Insured social security # \_\_\_\_\_

### Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_.  
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 \_\_\_\_\_ Date \_\_\_\_\_

Relation to Patient \_\_\_\_\_