

## **Insurance Information**

### **Primary Insurance Coverage**

Insurance Company \_\_\_\_\_

Name of Insured (as it appears on card) \_\_\_\_\_

Insured's DOB \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Co-pay \$ \_\_\_\_\_

### **Secondary Insurance Coverage**

Insurance Company \_\_\_\_\_

Name of Insured (as it appears on card) \_\_\_\_\_

Insured's DOB \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Co-pay \$ \_\_\_\_\_

### **Patient's Consent**

I hereby authorize the processing of the medical insurance either by electronic or manual method by Dr. Harbin / Dr. Franklin or their representative(s). My signature authorizes payment of all medical and /or surgical benefits to which I am entitled from the listed insurer(s) above to pay Dr. Harbin / Dr. Franklin for services rendered. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I recognize my financial obligation of any balance, co-insurance, deductible, and non covered services that may be required.

\_\_\_\_\_  
Signature of Subscriber or Beneficiary

\_\_\_\_\_  
Date