PROVIDER NAME DR. NEWIRTH BILLING INFORMATION

Patient Name: Date

PATIENT INFORMATION
Address:
City: State: Zip:
Home Ph:
Work Ph: Cell:
Date of Birth:
Soc. Sec. No.:
☐ Male ☐ Female
Marital Status: ☐ Single ☐ Married
Relationship to Patient or Insured:
☐ Self ☐ Spouse ☐ Child
☐ Employed ☐ Student ☐ Pt-Time ☐ Full-time
Employer/School Name:
Phone:

REFERRED BY:

PRIMARY HEALTH CARE PROVIDER
Name:
Address:
City: State: Zip:
Phone: Fax:

GUARANTOR IF OTHER THAN PATIENT
Name:
Address:
City: State: Zip:
Phone: Fax:
Relationship of Guarantor to Patient:
☐ Spouse ☐ Parent ☐ Guardian

PRIMARY INSURANCE COVERAGE
Insurance Carrier:
Group Number:
Ins. ID#:
Member Name:
Billing Address:
City: State: Zip:
Phone:
Effective date:

SECONDARY INSURANCE COVERAGE
Insurance Carrier:
Member Name:
Group Number:
Ins. ID#:
Address:
City: State: Zip:
Phone:
Effective date:

TERTIARY INSURANCE COVERAGE
Insurance Carrier:
Member Name:
Group Number:
Ins. ID#:
Billing Address:
City: State: Zip:
Phone:
Effective date:

ASSIGNMENT OF BENEFITS
My signature below authorizes and directs payment of medical benefits for services billed to my health care provider.

RELEASE OF MEDICAL RECORDS
My signature below authorizes the release of my medical records including intake forms, chart notes, reports, and billing statements to my attorney, health care providers, and insurance case managers, for the purpose of processing my claims.
FINANCIAL RESPONSIBILITY: It is my responsibility to pay for all services provided in the event that my insurance company denies payment or makes a partial payment, I am responsible for the balance. If you have contracted with my insurance company at a discount rate and the agreed upon fee has been satisfied, the balance will be waived.

Patient Signature: Date: