❑EST
❑NEW
❑CHANGE

❑ Practice: ____________________

❑ Hospital: ____________________

Insurance/Patient Liability

ACCT. NO.	DATE	APPT.	DR.	CLINIC EMP

DX	REFERRING DR.

PATIENT NAME	BIRTH DATE	PATIENT ADDRESS

SOCIAL SECURITY #	HOME PHONE #	WORK PHONE #

EMPLOYER ADDRESS

PATIENT SPOUSE D.O.B. SS#

PRIMARY INSURANCE

PRIMARY INSURANCE CO	INS. PHONE #	PRE-CERT PHONE #	ADDRESS	
INSURED'S NAME	❑SPOUSE ❑OTHER	POLICY #	GROUP #	PRECERT Y N C/H

❑ HMO ❑ PPO ❑ INDEMNITY ❑ CAPITATION	OV CO-PAY	REFERRAL REQ'D Y N	PCP NAME	PHONE #	AUTH. #

❑ IN NETWORK ❑ OUT OF NETWORK OUTSIDE LAB: ❑ QUEST ❑ LABCORP ❑ GMH ❑ OTHER:

DEDUCTIBLE	BALANCE DUE	CALENDAR/CONTRACT YEAR	VERIFIED WITH	
PAY RATE	% TO COP. COPAYMENT	BAL ON COP	YEARLY MAX	LIFETIME MAX

❑ BCBS ❑POS ❑ PPC ❑ HMO BLUE ❑ REG ❑ STATE ❑FED ❑ M/CARE SPLMT

❑ OTHER ❑CANCER ❑HOSP / SURGERY ONLY ❑OTHER:

❑ COBRA EFF: ENDS: PREMIUM PAID THRU: PRE EXIST: Y N

COMMENTS: CHEMO / IV / INJ

SECONDARY INSURANCE

SECONDARY INSURANCE	INS. PHONE #	ADDRESS		
INSURED'S NAME	❑SPOUSE ❑OTHER	POLICY #	GROUP #	INDIVIDUAL #

❑ HMO ❑ PPO ❑ INDEMNITY ❑ CAPITATION	OV CO-PAY	REFERRAL REQ'D Y N	PCP NAME	PHONE #	AUTH. #

❑ IN NETWORK ❑ OUT OF NETWORK OUTSIDE LAB: ❑ QUEST ❑ LABCORP ❑ GMH ❑ OTHER:

DEDUCTIBLE	BALANCE DUE	CALENDAR/CONTRACT YEAR
PAY RATE	% TO COP. COPAYMENT	BAL ON COP

❑ BCBS ❑POS ❑ PPC ❑ HMO BLUE ❑ REG ❑ STATE ❑FED ❑ M/CARE SPLMT

❑ OTHER ❑CANCER ❑HOSP / SURGERY ONLY ❑OTHER:

❑ COBRA EFF: ENDS: PREMIUM PAID THRU: PRE EXIST: Y N

COMMENTS: CHEMO / IV / INJ

THIS IS ONLY AN ESTIMATE OF YOUR LIABILITY BASED ON INFORMATION FROM YOUR INSURANCE CARRIER

ESTIMATED PATIENT LIABILITY	OV CO-PAY	OTHER SERVICES
DOWN PAYMENT	AMOUNT REC'D	METHOD OF PAYMENT ❑ CHECK ❑ CASH ❑ VISA ❑MC ❑OTHER ____________

MONTHLY PAYMENT ARRANGEMENTS

COMMENTS:

PATIENT/GUARANTOR SIGNATURE	DATE	CLINIC EMPLOYEE SIGNATURE	DATE
PATIENT/GUARANTOR SIGNATURE	DATE	FRONT OFFICE MANAGER SIGNATURE	DATE

WHITE – BUSINESS OFFICE COPY YELLOW: CHART COPY PINK – PATIENT COPY

08/25/05