Email:

Birth Date: / /

* Male  Female

Type of Plan (*circle one*) **PPO** **EPO POS Medicare Other**:

**Self-Pay**: $265/Evaluation and $155/Visit

|  |  |  |
| --- | --- | --- |
| PreAuth: No Rx: No | **In Network** | **Out of Network** |
| Does the patient’s plan fall under the Covered California plans? |  |  |
| What is the patient’s responsibility? |  |  |
| How many visits are allowed? |  |  |
| What is the patient’s deductible amount? **Individual** |  |  |
| What amount of the deductible has been met for **Individual**? |  |  |
| What is the patient’s deductible amount? **Family** |  |  |
| What amount of the deductible has been met for **Family**? |  |  |
| What is the patient’s out of pocket amount? **Individual** |  |  |
| What amount of the out of pocket has been met for **Individual**? |  |  |
| What is the patient’s out of pocket amount? **Family** |  |  |
| What amount of the out of pocket has been met for **Family**? |  |  |

Based on the figure that was provided by your insurance carrier(s), we have ESTIMATED that your patient responsibility will be

$\_\_ not including deductible portion and is due at the time services are rendered. You may have a co-pay amount that is more than what is charged for the date of service, in which case you may be billed for the difference. Should your co-pay amount be less than what was charged for the date of service, you will be refunded the difference. ***Please be advised that your insurance company may directly mail you a check(s) for the services rendered from our office (Cigna exempt). Check(s) need to be endorsed over to our office along with the EOB’s (Explanation of Benefits) for appropriate processing to your account.***

We have verified your benefits with your insurance carrier and we are informing you of these benefits. We are not responsible for your benefits and do not guarantee that your benefits will be paid by your insurance carrier.

It is your responsibility to pay any deductible amount, co-insurance, or any “non-covered” item(s) not paid by your insurance.

Group/Policy #:

Subscriber ID#:

Insurance Phone: ( ) -

Name of Secondary Insurance

Group/Policy #:

Subscriber ID #: G

Emer. Contact:

Insurance Phone: ( ) -

Primary Insurance Name:

**INSURANCE INFORMATION**

-

**PATIENT INFORMATION**

Condition to be treated:

* Former Patient  Close to Work/Home  Website  Street Sign  Other

Referred to Clinic By :  Dr.:  Insurance Plan  Family  Friend

Alt. Phone: ( ) -

Home Phone: ( ) -

Zip:

State:

City:

Address:

Date: / /

Initial:

Last Name:

First Name: