**INSURANCE INFORMATION:** Many of our patients are not covered through their insurance companies for out of network provider's. We recognize and appreciate this hardship. For those who do have insurance coverage for Out of Network PPO's, please fill out the following.

Subscriber's name (person's name the insurance is under)

_______________________________________________

Subscriber's address (if different than patient's)

______________________________________________________

Subscriber's Date of birth _____________

Subscriber's employer ________________________________________

Name of Insurance Company ____________________________________

ID # ____________________________

Group # _____________________________

If someone other than the PATIENT is responsible for payment, complete the following:

Name of responsible party__________________________________________

Phone __________________ Social Security # ___________________

Relationship to patient __________________

Address (if different from the patient's)

__________________________________________________________________

__________________________________________________________________

Date of birth ___________________

**Please sign and return to the office:**

I acknowledge that I am financially responsible for all charges whether of not they are covered by insurance.

Signature _______________________________________ Date________________