

Insurance Information

Primary Insurance _____

Claims Address _____

Contact Phone Number for Benefits _____

Name of Insured _____ Insured's DOB _____ Insured's Social # _____

Group Number _____ Policy Number _____
(Blue Cross / Blue Shield MUST include alpha prefix)

Secondary Insurance _____

Address _____

Contact Phone Number for Benefits _____

Name of Insured _____ Insured's DOB _____ Insured's Social # _____

Group Number _____ Policy Number _____
(Blue Cross / Blue Shield MUST include alpha prefix)

Authorization to Release Information and Assignment of Insurance Benefits

I hereby authorize G. William Salvador, M.D. to:

- 1) Furnish my insurance company with any/all information requested concerning my present claim(s).
- 2) Bill my insurance company, and to accept payment from that company on my behalf, for all services from time to time relating to my care.

I acknowledge that I am responsible for all charges not covered by my insurance. I understand that any money received from my insurance company by G. William Salvador, M.D., in excess of my bill will be refunded to me after completion of treatment. I also understand that I will be charged for any appointment I fail to keep or cancel at least 48 hours prior to the appointment time, and I agree to pay these charges in full.

Patient's signature

Date

Responsible party's signature if patient is a minor

727 SE Cass Ave, Suite 325
Roseburg, OR 97470
Phone: 541-957-5762
Fax: 541-343-6434

401 East 10th Ave, Suite 230
Eugene, OR 97401
Phone: 541-684-0154
Fax: 541-343-6434