G. William Salbador, MD, PC Adult
& Geriatric Psychiatry

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 Salbador, 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 Salbador, 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

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