

## ***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