DR. JAMES SHAVER
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LANDIS, NC 28088
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SIGNATURE ON FILE

OUR POLICY: THE PATIENT IS RESPONSIBLE FOR ALL BILLS INCURRED. WE WILL FILE INSURANCE CLAIMS AS A COURTESY FOR OUR PATIENTS. IF FULL PAYMENT HAS NOT BEEN RECEIVED FROM INSURANCE WITHIN 6 WEEKS OF THE DATE OF SERVICE, PAYMENT WILL THEN BE DUE FROM THE PATIENT.

I REQUEST PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF TO DR. JAMES SHAVER FOR ANY SERVICES FURNISHED ME.

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION ABOUT ME TO AUTHORIZED AGENCIES TO DETERMINE BENEFITS PAYABLE FOR RELATED SERVICES.

PRIMARY INSURANCE

INSURANCE CO: _____

PATIENT NAME ON CARD: _____

SS#/ID#: _____ DATE OF BIRTH: _____

SIGNATURE: _____ DATE: _____

SECONDARY INSURANCE

INSURANCE CO: _____

PATIENT NAME ON CARD: _____

SS#/ID#: _____ DATE OF BIRTH: _____

SIGNATURE: _____ DATE: _____