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 IS NOT 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: _____

NAME ON CARD: _____

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

SECONDARY INSURANCE

INSURANCE CO: _____

NAME ON CARD: _____

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

SIGNATURE: _____ DATE: _____