INSURANCE INFORMATION

As a courtesy, we will bill your insurance company for you. Please note that this does not guarantee payment by your insurance and you are responsible for all charges that apply if your insurance fails to pay correctly and/or in a timely manner.

Patient Name: _____ Patient Date of Birth: _____
Subscriber Name _____Subscriber's Date of Birth:_____
Insurance Company: _____
Subscriber # or SS: _____ Group #:_____
Employer Name: _____
Subscriber Relationship to Patient:_____
Subscriber's Address if different than patient:_____
Phone Number: _____

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I authorize the release of any medical information necessary to process this claim. I also authorize all claims to be sent directly to my insurance company and I authorize payment to be made directly to Cornerstone Wellness Center. I also agree to pay for any co-pay, deductible, or percentages designated as my responsibility. In the event that I should receive payment for these services, I agree to promptly remit payment to Cornerstone Wellness Center. I also accept personal responsibility for any balance due.

_____ _____
Patient or Responsible Party Signature **Date**
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