

Authorization to Bill Third-Party Payer

INS

SECTION 1: Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

DOB: _____ SS#: _____ Daytime Phone: (_____) _____

SECTION 2: Benefits and Billing Information

Please notify the front desk staff if your visit is related to an injury or accident

I. Does your insurance have alternative medicine benefits? Yes No

Who is your Primary Care Provider?: Dr. _____ Clinic Phone #: (_____) _____

Clinic Address: _____ City: _____ State: _____ Zip Code: _____

Does your plan require you to have a referral from you Primary Care Provider to receive coverage? Yes* No

*If yes, which licensed provider were you referred to at our clinic?: _____

II. Primary Insurance Company & Plan Name: _____

ID Number: _____ Group/Policy Number: _____

Name of Policy Holder: _____ Policy Holder's Date of Birth: _____

The policy holder is my: _____ (specify relationship) Policy Holder's Gender (circle): Male Female

Is your Primary Insurance Policy a (circle): POS PPO EPO HMO Don't Know Other (specify): _____

III. Secondary Insurance Company & Plan Name: _____

ID Number: _____ Group/Policy Number: _____

Name of Policy Holder: _____ Policy Holder's Date of Birth: _____

The policy holder is my: _____ (specify relationship) Policy Holder's Gender (circle): Male Female

Is your Secondary Insurance Policy a (circle): POS PPO EPO HMO Don't Know Other (specify): _____

SECTION 3: Guarantor Information

This section must be completed if someone other than the patient is financially responsible for the patient's account.

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: (_____) _____

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient and that I am subject to all financial terms listed below.

X _____
Guarantor's Signature Date

I understand that all co-pays are due at the time of service and that I am financially responsible for all charges whether or not they are paid by my insurance. I understand that finance charges will begin accruing on accounts that are 60 days past due for payment at a rate of 1.5% per month. I further understand that excessively overdue accounts will be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that some third-party payers may require that my medical information, including copies of treatment notes, be submitted along with requests for payment. I hereby authorize Sound Integrative Health, PLLC to release all medical information necessary to secure payment of benefits from the third-party payers specified above, and I authorize the use of this signature on all related submissions. I understand that this information may include medical information related to drug and alcohol abuse, sexually transmitted diseases, HIV/AIDS and mental health. I understand that this authorization shall remain valid without expiration unless expressly revoked by me in writing.

X _____
Patient's Signature Date

X _____
Guardian/Representative's Signature Date

Relationship to Patient/Representative Authority

