

Insurance Information

Primary Health Care Provider: _____

Telephone #: _____ Extension: _____

Permission to Consult with Primary Provider? No Yes _____ (please initial if yes)

Referring Health Care Provider (if different from above): _____

Telephone #: _____ Extension: _____

Permission to Consult with Referring Provider? No Yes _____ (please initial if yes)

Insurance Carrier: _____ Telephone #: _____

Name of Insurance Plan/Program: _____

Insurance ID: _____ Group ID: _____

Co-pay Amount (if applicable): _____

Name of Insured (if you are carried on someone else's policy): _____

Address (if different): _____

City: _____ State: _____ Zip: _____

Daytime Phone #: _____ Evening Phone #: _____

Email Address: _____ Relationship to you: _____

Date of Birth: _____ Sex: _____

Occupation: _____ Employer or School: _____

Please check each box to indicate you have read and agree to the following statements and sign below:

- I authorize Jonathan Drummey to give my insurance company any and all information necessary for consideration of insurance claims for the above named client.
- I authorize Jonathan Drummey to be paid directly for services billed on insurance claims for the above named client.

Client (or Guardian) Signature

Date