LEGACY HEALTH & WELLNESS
VEIN.HORMONE.LASER.IV.SPECIALISTS.

Insurance Information

Patient's Name: _____ Date: _____
First Middle Last

[Primary Insurance]

Name of Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Insured's Name: _____

Group Number: _____ Policy ID Number: _____

[Secondary Insurance]

Name of Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Insured's Name: _____

Group Number: _____ Policy ID Number: _____

Did your injury happen on the job? Yes No

If yes, on what date did the injury occur? _____

Did you report the accident to your employer? Yes No

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay, and non-covered service amounts. See our complete financial policy for details.

Method of Payment for Today's Visit: ___Cash ___Check ___Visa/MC

Signature of Patient or Responsible Party: _____

Date: _____

I authorize the release of any medical information necessary to process my claim.

Signed: _____ Date: _____
(Patient or responsible party)

I authorize payment of medical benefits to *Legacy Health & Wellness*

Signed: _____ Date: _____
(Patient or responsible party)