

Arthritis and Osteoporosis Associates
Insurance Information

Prescription RX Insurance _____ **Policy or Member ID** _____
Phone Number _____

Primary Insurance _____ **Policy or Member ID** _____
Group # _____ **Name of Subscriber** _____ **D.O.B.** ___/___/___
Relationship _____

Secondary Insurance _____ **Policy or Member ID** _____
Group # _____ **Name of Subscriber** _____ **D.O.B.** ___/___/___
Relationship _____

Tertiary Insurance _____ **Policy or Member ID** _____
Group # _____ **Name of Subscriber** _____ **D.O.B.** ___/___/___
Relationship _____

INSURANCE AUTHORIZATIONS AND ASSIGNMENT, AND PAYMENT RESPONSIBILITY: I hereby authorize Arthritis and Osteoporosis Associates to furnish information to any and all insurance carriers concerning my medical records and treatments. I authorize Arthritis and Osteoporosis Associates to appeal any unpaid insurance claims on my behalf. I hereby assign to the physicians all payments for medical services rendered to myself to my dependents. I acknowledge and understand that I am responsible for all services rendered to me and all the charges incurred from those services. Although I have requested the practitioner to bill my insurance company on my behalf, I clearly understand that I am responsible for any amount not covered by my insurance for any reason. I will also be responsible for my co-pays, co-insurance amounts, and deductibles. Any payments made directly to the patient and owing to the physicians will be remitted immediately, payable to Arthritis and Osteoporosis Associates. Payment is expected when services are rendered. I am responsible for furnishing all the information requested above, and also responsible for furnishing any necessary insurance forms to the office prior to hospitalization or office surgical procedures. IF THERE IS A DEFAULT IN ANY ONE PAYMENT (NO PAYMENT WHEN DUE) THERE WILL BE AN ADDED 25% COLLECTION OR ATTORNEY'S FEE, PLUS ALL COSTS, IF MY ACCOUNT GOES TO A COLLECTION AGENCY OR COLLECTION ATTORNEY FOR COLLECTION OR LITIGATION.

Signature authorizing ALL statements above _____ **Date** ___/___/___
Print Name: _____ **Date of Birth:** ___/___/___