Billing & Assignment of Benefits Form

Date of Service

Date

Circle One If Applays

○ **MVA** ○ **WC**

Patient's Name

Your name

DOB

Date Of Birth

Sex

○ **Male** ○ **Female** ○ **Other**

Patient's SS#

Phone Number

Home Phone

Phone Number

Address

Address

Apartment Number

Apartment Number

City

City

State

State

Zip Code

Zip Code

Insurance : Copy of Insurance Card/s?

○ **Yes** ○ **No**

Primary Insurance Info

Insurance Name

Insurance Name

Policy Number

Policy Number

Subscriber's Name

Subscriber's Name

Subscriber DOB

Subscriber DOB

Subscriber's Relation to Patient

○ **M** ○ **F** ○ **H** ○ **W** ○ **Other**

Address

Address

Apartment Number

Apartment Number

City

City

State

State

Zip Code

Zip Code

Secondary Insurance Info

Insurance Name

Insurance Name

Policy Number

Policy Number

Subscriber's Name

Subscriber's Name

Subscriber DOB

Subscriber DOB

Subscriber's Relation to Patient

○ **M** ○ **F** ○ **H** ○ **W** ○ **Other**

Address

Address

Apartment Number

Apartment Number

City

City

State

State

Zip Code

Zip Code

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION

I authorize the release of any medical and/or employment information necessary to the above named insurance company, and/or attorney to process any claims and request that payment of medical benefits be assigned to **Tree of Life Integrative Family Medicine** understand that I am responsible for payment of medical services rendered. If any checks are sent directly to me by my insurance carrier, I will forward the check to **Tree of Life Integrative Family Medicine**

Parent, Guardian, or Authorized Signature

Date

Date