

# Billing & Assignment of Benefits Form

## Date of Service

Date

## Circle One If Applies

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****State****Zip Code****Insurance : Copy of Insurance Card/s?**

Yes  No

## Primary Insurance Info

**Insurance Name****Policy Number****Subscriber's Name****Subscriber DOB****Subscriber's Relation to Patient**

M  F  H  W  Other

**Address****Apartment Number**

**City****State****Zip Code**

## Secondary Insurance Info

**Insurance Name****Policy Number****Subscriber's Name****Subscriber DOB****Subscriber's Relation to Patient**

M  F  H  W  Other

**Address****Apartment Number****City**

**State**

State

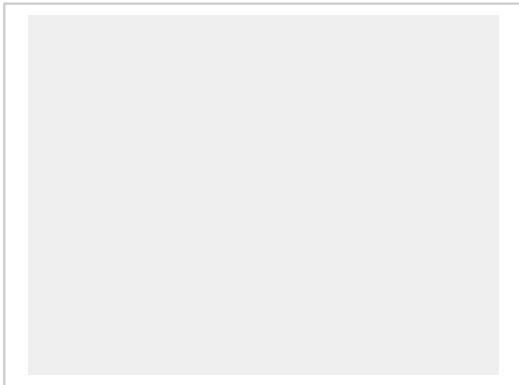
**Zip Code**

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