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1030 St. Georges Ave. (Rte. 35)
Avenel, NJ 07001
Phone: (732) 750-0303

PRIMARY INSURANCE INFO:

INSURANCE COMPANY: _____

INSURANCE ID#: _____

POLICY HOLDER'S NAME: _____

POLICY HOLDER'S DATE OF BIRTH: _____

POLICY HOLDER'S SOCIAL SECURITY #: _____

RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ PARENT/GUARDIAN ☐ OTHER

SECONDARY INSURANCE INFO:

INSURANCE COMPANY: _____

INSURANCE ID#: _____

POLICY HOLDER'S NAME: _____

POLICY HOLDER'S DATE OF BIRTH: _____

POLICY HOLDER'S SOCIAL SECURITY #: _____

RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ PARENT/GUARDIAN ☐ OTHER

TERTIARY (3RD) INSURANCE INFO:

INSURANCE COMPANY: _____

INSURANCE ID#: _____

POLICY HOLDER'S NAME: _____

POLICY HOLDER'S DATE OF BIRTH: _____

POLICY HOLDER'S SOCIAL SECURITY #: _____

RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ PARENT/GUARDIAN ☐ OTHER

INSURANCE AUTHORIZATION

I hereby authorize the processing of my medical insurance either by electronic or manual method by FAMILY PODIATRY CENTER. My signature authorizes payment of all major medical and/or surgical benefits, to which I am entitled from the listed Insurer(s) above, to pay the listed Provider Assignee. I further authorize the Assignee to release all medical and/or insurance claim information necessary to secure the payment(s). I recognize my financial obligation of any co-insurance or deductible, and non-covered services that may be required. This agreement will remain in effect until revoked by me in writing. A copy of this document is considered as valid as an original.

PATIENT NAME: _____

PATIENT SIGNATURE: _____

DATE: _____