Welcome to our Practice!

PATIENT INSURANCE INFORMATION FORM

Southern Tier Cancer Care

PLEASE PRINT INFORMATION Date: ____________________

Patient ________________________________ Social Security#: ____________ DOB: ________

Last Name First Name Initial

Home Phone: _________________________ **Cell Phone**: ____________________________

Home Address: ____

City____________________ State: _____ Zip: __________

Patient Employed By: ____

Work Address: ____

Occupation: ______________________________ Work Phone: __________________________

Spouse Employed By: _______________________ Spouse's Social Security#: _____________________

Work Address: ____

Occupation: ______________________________ Work Phone: __________________________

PRIMARY INSURANCE: ________________________________ Phone#: ___________________

Policy #: ___________________ Group#: ___________________ Subscriber #: _________________

Name of Policy Holder: ________________________ Date of Birth: _________ Auth #: ____________

Subscriber's Employer Name/Address: ____

SECONDARY INSURANCE: ________________________________ Phone#: ___________________

Policy #: ___________________ Group#: ___________________ Subscriber #: ___________________

Name of Policy Holder: ________________________ Date of Birth: ____________ Auth #: __________

Subscriber's Employer Name/Address: ____

How were you referred to our practice? Physician/Friend/Relative--If so, name______________________

Yellow Pages / Mail / Newspaper /Hospital referral Other__________________________________

Responsible Party (if minor)____

All patient payments for all office services are due at the tome of your visit unless other arrangements have been made prior to services being rendered.

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Patient Release:

I understand that insurance is considered a method of reimbursing the patient for fees paid to the physician, but is usually not designed to pay the entire fee. Because insurance companies vary the amount they will pay for various services, **it is ultimately MY responsibility to pay the portion of the bill not paid by my insurance company** (unless otherwise restricted by law or agreement we might have with insurer). If the account becomes delinquent for any reason this balance may be sent to collection services. I accept responsibility for any collection and attorney fees if payment is not received in a timely manner. In addition, this debt may be listed on my credit report.

By signing this, I certify that all the above information is true and correct. I hereby assign all medical benefits payments to be made on my behalf to SOUTHERN TIER CANCER CARE for any services furnished to me. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for purpose of filing and payment of medical claims. I ACKNOWLEDGE THAT INTEREST OR A FEE, AT THE PROVIDER'S CURRENT RATE, MAY BE CHARGED on all balances owing to the provider that are past due. Regulations pertaining to Medicare assignment of benefits apply. I have read and understood the notice of privacy practices presented to me. This assignment and release will remain in effect until revoked by me in writing. I permit a copy of this authorization to be used in place of the original.

Signature: _________________________ Date: ______________________