Insurance Information

Primary Insurance Company_______________________________________

Claims Address____

____

Telephone Number____

ID #_____________________ Group #___________________________

Subscriber (primary insured)____

Subscriber SS#_______________________ Subscriber Birth Date____________________

Subscriber's employer____

Relationship of Patient to subscriber___________________________________

Secondary Insurance Company_______________________________________

Claims Address____

____

Telephone Number____

ID #_____________________ Group #___________________________

Subscriber (primary insured)____

Subscriber SS#_____________________ Subscriber Birth Date__________________________

Subscriber's employer____

Relationship of Patient to subscriber___________________________________

Assignment of Insurance/Medicare Benefits

I hereby give consent for medical or surgical treatment to the physician to care for myself or I am duly authorized by the patient as his/her guarantor to give consent for such treatment. Dr Azar is ONLY contracted with Medicare, no other insurance.

I understand that charges are payable on the day service is rendered. I authorize Dr. Azar to bill my insurance company. I hearby authorize payment directly to the physician of any medical / surgical benefits payable to me under the conditions of my policy for services rendered. I hearby give consent to release to authorized persons of financial and medical information concerning care, treatment and charges as may be required to complete all claims for benefits. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Azar and myself. In the event of collection action, I shall be responsible for any legal fees incurred as a result of the collection action.

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Patient (or Responsible Party) Signature Date