



**Seawind Medical Clinic**

**INSURANCE INFORMATION**

PATIENT'S NAME: \_\_\_\_\_

PATIENT'S SS#: \_\_\_\_\_

POLICY HOLDER'S NAME: \_\_\_\_\_

POLICY HOLDER'S ADDRESS: \_\_\_\_\_

POLICY HOLDER'S D.O.B. \_\_\_\_\_

POLICY HOLDER'S PHONE #: \_\_\_\_\_

POLICY HOLDER'S SS#: \_\_\_\_\_

NAME OF INSURANCE COMPANY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE #: \_\_\_\_\_

INSURANCE GROUP #: \_\_\_\_\_

INSURANCE POLICY #: \_\_\_\_\_

YOUR RELATIONSHIP TO THE INSURED: \_\_\_\_\_

INSURANCE VERIFICATION OR IDENTIFICATION CARDS DO NOT CONSTITUTE GUARANTEE OF PAYMENT BY THE COMPANY. THEREFORE, 30 DAYS FROM THE BILLING DATE OF YOUR SERVICES. YOUR ACCOUNT WILL BE CONSIDERED AS A CASH ACCOUNT AND YOU (THE PATIENT) (GUARDIAN OR PARENT IF MINOR) WILL BE RESPONSIBLE FOR FULL PAYMENT OF THE ACCOUNT. YOU ARE ALSO RESPONSIBLE FOR ANY CO-PAYS, DEDUCTIBLES OR NON-COVERED SERVICES. ANY MONIES SUBSEQUENTLY PAID BY THE INSURANCE COMPANY WILL BE REFUNDED TO YOU. I ALSO UNDERSTAND THAT IF MY ACCOUNT IS PURSUED FOR COLLECTION. BECAUSE OF NON-PAYMENT, I AM RESPONSIBLE FOR ANY FEES INCURRED.

ALSO, BY SIGNING THIS FORM, YOUR SIGNATURE RELEASES ANY AND/OR ALL OF YOUR MEDICAL RECORDS TO THE COMPANY. THE CARD OF THE INSURANCE CARRIER YOU PROVIDED US WITH IS COPIED ON THE REVERSE SIDE OF THIS FORM.

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_