Patient Financial Responsibility Form

Primary Insurance Co:_____Phone ( )_____

*Address:*_____ *City:*_____*State:*_____*Zip:*_____

*Policy Holder's Name:*___*_____Relation:*_____

*ID #:*_____*Group #:*_____*Policy #:*_____

Secondary Insurance Co:_____Phone ( )_____

*Address:*_____ *City:*_____*State:*_____*Zip:*_____

*Policy Holder's Name:*_____*Relation:*_____

*ID #:*_____*Group #:*_____*Policy #:*_____

Note: If a patient is a dependent or spouse of the "insured" please complete responsible party information below. Please present your insurance cards and a form of identification.

Insured / Responsible Party

*Name:*_____*DOB:*_____/_____/_____ *SS#*_____/_____/_____

*Address:*_____*City:*_____*State:*_____*Zip:*_____

*Phone:( )*_____*Relationship:*_____

*Employer:*_____ *Phone:( )*_____

*Address:*_____*City:*_____*State:*_____*Zip:*_____

Attorney

*Name:*_____*Phone: ( )*_____

*Address:*_____*City:*_____*State:*_____*Zip:*_____

In order to control our cost of billing, we request that office visits and treatment be paid at the time service is rendered. We would rather control our billing costs than be forced to increase our fees.
Authorization: I hereby authorize ***Carrasco Pain Institute, its physicians, and other ancillary services.*** *to release information to insurance carriers concerning this illness/accident, and hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.*

*Patient Signature:*_____*Date:*_____