INSURANCE

NAME:_____

Who is responsible for this account?_____

Relationship to patient_____

Birthdate_____Social Security #_____

Insurance Company_____

Group #_____ID #_____

Is patient covered by additional insurance? O Yes O No

Subscriber's Name_____

Birthdate_____Social Security #_____

Relationship to patient_____

Insurance Company_____

Group #_____ID #_____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with_____
Name of Insurance Company/Companies

Assign directly to **The Bowen Center for Women's Health** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named medical practice may use my health care information and may disclose such information to the above named insurance company/companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end one year from the date signed below.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits and , if applicable, Medigap benefits, be made either to me or on my behalf to **The Bowen Center for Women's Health** for any services furnished to me by that medical practice.

To the extent permitted by law, I authorize any holder or medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap Insurer and their agents any information needed to determine these benefits or benefits for related services.

Signature of Patient, Parent, Guardian or Personal Representative Date

Please Print Above Name State Relationship to Patient