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PATIENT INFORMATION UPDATE

NAME _____

ADDRESS _____

HOME PHONE _____

CELL PHONE _____

PRIMARY INSURANCE _____

SECONDARY INSURANCE _____

ANNUAL DEDUCTIBLE _____

ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION RELATED TO MEDICAL SERVICES PROVIDED

I, HEREBY, ASSIGN ALL BENEFITS TO STEFAN FROLOV, M.D. FOR SERVICES RENDERED TO ME OR SAID MINOR PATIENT. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME OR SAID MINOR TO RELEASE TO MY INSURANCE COMPANY ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

I UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENT BE MADE TO STEFAN FROLOV, M.D. AND AUTHORIZE RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM. I HAVE GIVEN ALL MY INSURANCE INFORMATION FOR BILLING PURPOSES AND UNDERSTAND THE BILLING PROCEDURES.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MY INSURANCE POLICY INCLUDING BUT NOT LIMITED TO, CO-PAYMENTS, DEDUCTIBLES, AND NON-COVERED SERVICES. I ALSO AGREE TO COMPLETE ALL NECESSARY PAPERWORK IN ORDER FOR MY CLAIM TO BE PAID BY MY INSURANCE COMPANY AND ACCEPT FULL LIABILITY FOR ALL CHARGES IF PAYMENT IS NOT MADE IN MY BEHALF BY M INSURANCE COMPANY.

SIGNED, PATIENT (OR PARENT IF MINOR) _____ **DATE**_____

IF OTHER THAN PARENT, RELATIONSHIP_____