INSURANCE INFORMATION

MARY E LMT, LLC

Insurance Information

Auto Insurance – fill in part A and C only Health Insurance – fill in part B and C only

PART A

Name of Insurance Co:

Address:

Claim/Policy No.

Name of Insured: ____ Relation to Patient: _________________

Attorney (if any):____ Phone Number: _______________________

Date of Injury: __________________________ Phone Number: __________________________

Contact Person: __________________________

Referring Physician:____________________________________

Contact:____

PART B

Name of Insurance Company: ID No.

Part C

Phone Number: __________________________

Name of Insured: _______________________ Group No: _______________________________

I authorize the release of medical records necessary to process this claim. I authorize payment by insurance company be made directly to the provider of services.

I understand the fees for services rendered will be directly billed to the above listed insurance company. I understand that I will be billed and held responsible for any fees for any services unpaid or not covered by the insurance company.

Signature: ____Date ____________________

Cancellation Policy: In order to avoid a 50% charge to your credit card, please provide Mary E LMT LLC at least 24 hour notice when rescheduling or canceling your appointment.______ (initial)