HEALTH INSURANCE INFORMATION

YOUR NAME:(LAST NAME)_____, (FIRST NAME)_____
(MIDDLE INITIAL)_____
YOUR DATE OF BIRTH: _____/_____/_____ (REQUIRED)
YOUR SOCIAL SECURITY NUMBER: _____-_____-_____

YOUR FULL HOME ADDRESS: _____
STREET AND APARTMENT NUMBER

_____
CITY STATE ZIP

PERSON RESPONSIBLE FOR THE ACCOUNT AND OR NAME THE INSURANCE PLAN IS UNDER:
(LAST NAME)_____, (FIRST NAME)_____
(MIDDLE INITIAL)_____RELATIONSHIP TO YOU:_____
INSURED'S OCCUPATION:_____
INSURED'S DATE OF BIRTH ____/____/____
EMPLOYER OF THE INSURED:_____
EMPLOYER OF THE INSURED ADDRESS:_____
STREET AND SUITE NUMBER

_____
CITY STATE ZIP

INSURANCE COMPANY NAME:_____
SUBSCRIBER ID/SS#:_____
GROUP #:_____CONTRACT #:_____
INSURANCE COMPANY PROVIDER TELEPHONE NUMBER:_____
INSURANCE BILLING ADDRESS:_____

PLEASE GIVE FRONT DESK YOUR HEALTH INSURANCE CARD SO WE MAY COPY IT. THANK YOU.

I, the undersigned certify that I (or my dependent) have insurance coverage with the aforementioned health insurance company and assign directly to Dr. Lauren Evans (Balance is Bliss, Inc.) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that this document must be signed in order for the doctor to process health insurance billing. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

RESPONSIBLE PARTY SIGNATURE:_____
DATE: _____/_____/_____ RELATIONSHIP TO PATIENT: _____