MEDISTOP CLINIC

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Insurance

Insurance: _____ Self-Pay: _____

Policy Holder's Name: _____ Date of Birth: ___/___/_____

Policy Number: _____ Policy Holder's SS#: ____ - ____ - _____

Relationship to Patient: _____

Employer: _____ Phone: _____

Work Address: _____ City: _____ State: _____ Zip: _____

Insurance Disclaimer:

"A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of member's contract at time of service."

Insurance Liability for Payment:

Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by this office to have all services and procedures preauthorized by your health insurance company. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular is not covered under the plan, your insurer will deny the payment for that service.

Beneficiary Agreement:

I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, **I WILL BE RESPONSIBLE FOR ANY CO-PAYMENY, DEDUCTABLE, OR COINSURANCE THAT APPLIES.**

_____
Patient Name (Print)

_____ _____
Patient Signature Date

_____ _____
Parent or Guardian's Name (Print) Parent or Guardian's Signature