

OCCUPATION

EMPLOYER

EMPLOYER PHONE #

PRIMARY INSURANCE

GROUP #

POLICY #

CO-PAY

SUBSCRIBER'S NAME

SS #

BIRTHDATE

PATIENT'S RELATIONSHIP TO SUBSCRIBER

SECONDARY INSURANCE (IF APPLICABLE)

EMERGENCY CONTACT

RELATIONSHIP TO PATIENT

TELEPHONE #

All professional services rendered are charged to the patient and due at the time of service. Necessary forms will be completed to help expedite payment for non-cosmetic procedures. However, the patient is responsible for all FEES, regardless of insurance coverage.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I hereby authorize Jennifer L. Walden, M.D. to furnish information to Insurance carriers concerning my illness and treatment and hereby assign to her all payments of medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

DATE _____ SIGNATURE _____