Facey Medical Group

EMR #: ___________

Insurance & Financial Responsibility Information

Patient Name: ______________________________ Date of Birth (mm/dd/yyyy): ____/____/________

Social Security #: ____ – ____ – ________

Primary Spoken Language: ______________________________

Street Address (home): ______________________________

City: ____________ State: ______ ZIP: ________

Email Address: ______________________________

DO YOU HAVE HEALTH INSURANCE? ☐ **YES** ☐ **NO**

Primary Health Insurance

Insurance Company: ______________________________

Insurance Phone #: ______________________________

Subscriber's Name: ______________________________

Subscriber's Employer: ______________________________

Subscriber's Date of Birth: ____/____/________

Subscriber's Social Security #: ____ – ____ – ________

Policy #: ______________________________

Group #: ______________________________

Effective Date: ____/____/________

Secondary Health Insurance (if any)

Insurance Company: ______________________________

Insurance Phone #: ______________________________

Subscriber's Name: ______________________________

Subscriber's Employer: ______________________________

Subscriber's Date of Birth: ____/____/________

Subscriber's Social Security #: ____ – ____ – ________

Policy #: ______________________________

Group #: ______________________________

Effective Date: ____/____/________

ASSIGNMENT OF BENEFITS

I hereby authorize and direct my insurance company to make payments to **Facey Medical Group and Providence Facey Medical Foundation**, benefits allowable and otherwise payable to me and/or my dependents. I understand that I am responsible for charges not paid under this Assignment. This Authorization will remain in effect until rescinded by myself in writing. A photocopy of this Assignment may be honored.

PATIENT SIGNATURE: ______________________________ DATE: ____/____/________

EMPLOYEE/WITNESS SIGNATURE: ______________________________ DATE: ____/____/________