Date: ___________________ Doctor: _____________________ Chart # _______________

Thank you for selecting our healthcare team!
To help us file your insurance, please
fill out this form completely.

Primary Insurance (Please provide insurance card for us to copy) **Co-Pay Amount $** _______________

Name of Insured (as it appears on the card): ____________________________ SS # ______________________

Relationship to Patient: _______________________________ DOB: ________________

Contract ID # ______________________________________ Group # _______________

Employer Name: ________________________________ City: ____

Effective Date of Coverage: __________________________________

Secondary Insurance (Please provide insurance card for us to copy) **Co-Pay Amount $** _______________

Name of Insured (as it appears on the card): ____________________________ SS # _______________________

Relationship to Patient: __________________________________ DOB: ________________

Contract ID # ____ Group # _____________

Employer Name: ________________________________ City: ____

Effective Date of Coverage: _______________________________

Referring Physician: _____________________________________

Current Problem: ____

PATIENT SIGNATURE AUTHORIZATION/RELEASE OF INFORMATION

I hereby consent to and authorize TOC to furnish any insurance company, organization, hospital, physician or pharmacist any information requested with respect to any physical or mental condition and/or treatment of me or my child.

I understand the information obtained by this authorization will be used to determine eligibility for insurance and eligibility for benefits under my insurance coverage. Any information will not be released except to persons or organizations performing business or legal services in connection with the claim, or as may be otherwise lawfully required or as I may further authorize.

I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

____ _________________________

Signature of Patient and/or Authorized Representative Date

Thank you for filling out this form completely. The information you have provided will help us serve your healthcare needs more effectively and efficiently.