

HORIZONS DIAGNOSTICS, LLC

DATE ____/____/____

ACCOUNT# _____

BILLING INFORMATION

NAME: _____

ADDRESS: _____

CITY, STATE, ZIP _____

HOME TELEPHONE _____ WORK TELEPHONE _____ EXT: _____

PATIENTS INFORMATION

PATIENT NAME: _____

ADDRESS: _____

CITY, STATE, ZIP _____

HOME TELEPHONE _____ EMERGENCY PHONE _____

EMERGENCY CONTACT: _____ RELATIONSHIP _____

DATE OF BIRTH _____ SEX M F MARITAL STATUS S M D W

SOCIAL SECURITY # ____ - ____ - ____ AGE _____

EMPLOYER: _____ EMPLOYER PHONE: _____ EXT _____

EMPLOYER ADDRESS: _____

OCCUPATION: _____ STUDENT Y N FULLTIME/PARTTIME _____

HEALTH INSURANCE INFORMATION

PRIMARY CARE PROVIDER: _____

PRIMARY INSURANCE COMPANY

NAME: _____

POLICY # _____ GROUP# _____

POLICY HOLDER'S NAME _____ POLICY HOLDER'S DATE OF BIRTH _____

POLICY HOLDER'S ADDRESS _____

POLICY HOLDER'S HOME PHONE: _____ POLICY HOLDER'S WORK # _____ EXT _____

POLICY HOLDER'S SEX: M F POLICY HOLDER'S SOCIAL SECURITY # ____ - ____ - ____

POLICY HOLDER'S EMPLOYER: _____

POLICY HOLDER'S EMPLOYER ADDRESS: _____

HORIZONS DIAGNOSTICS, LLC

SECONDARY INSURANCE COMPANY NAME: _____

POLICY # _____ GROUP# _____

POLICY HOLDER'S NAME _____ POLICY HOLDER'S DATE OF BIRTH _____

POLICY HOLDER'S ADDRESS _____

POLICY HOLDER'S HOME PHONE: _____ POLICY HOLDER'S WORK # _____ EXT _____

POLICY HOLDER'S SEX: M F POLICY HOLDER'S SOCIAL SECURITY # _____ - _____ - _____

POLICY HOLDER'S EMPLOYER: _____

POLICY HOLDER'S EMPLOYER ADDRESS: _____

ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE OF INFORMATION

I HEREBY AUTHORIZE ANY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN PROVIDING SERVICES AND RECOGNIZE MY RESPONSIBILITY TO PAY FOR ALL NON-COVERED SERVICES. I ALSO AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION NECESSARY TO PROCESS AN INSURANCE CLAIM.

I HEREBY CONSENT TO SUCH DIAGNOSTIC PROCEDURES AND TREATMENT DEEMED NECESSARY OR ADVISABLE WHILE A PATIENT AT HORIZONS DIAGNOSTICS, L.L.C.

SIGNATURE: _____ DATE: _____

Revised 03/01

merritt