Print Form

INSURANCE INFORMATION

Patient _____

PRIMARY INSURANCE

Insurance Company _____

Policy # _____ Group # _____

Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____ Relationship to Patient _____

Birthday ____/____/_____ S.S.# _____ Driver's License # & State _____

Employer _____ Occupation _____

Address _____ Suite _____

City _____ State _____ Zip _____

SECONDARY INSURANCE

Insurance Company _____

Policy # _____ Group # _____

Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____ Relationship to Patient _____

Birthday ____/____/_____ S.S.# _____ Driver's License # & State _____

Employer _____ Occupation _____

Address _____ Suite _____

City _____ State _____ Zip _____

SIGNATURE ON FILE	MEDICAL RELEASE ON FILE
I authorize payment of insurance medical benefits, if any, directly to Alvin J. Aubry, Jr., M.D., when insurance is accepted in partial payment of my account. I understand that I am responsible for the final full payment of this account. Signature _____ (Patient or authorized person) Date _____ Driver's License # _____ State _____	I authorize the release of all medical information necessary to process insurance claims for Patient _____ (Please print) Signature _____ (Patient or authorized person) Date _____

We will be happy to file your insurance for you. Please understand that you are responsible for the final settlement of your charges regardless of insurance coverage.

We gladly accept Cash, Checks, MasterCard, Visa and American Express.

The receptionist will need to see your insurance card and your driver's license.

Revised 01/2005