Phone: (833) 473-8562 Fax: (702) 778-9913

PATIENT INSURANCE

(PLEASE PROVIDE COPIES OF ALL INSURANCE CARDS TO FRONT DESK STAFF)

PRIMARY INSURANCE

INSURANCE COMPANY: ___________________________________

MEMBER ID: ___________________________________ GROUP ID: ___________________________

SECONDARY INSURANCE

INSURANCE COMPANY: ___________________________________

MEMBER ID: ____________________________________ GROUP ID: ___________________________

VISION INSURANCE

COMPANY: ___________________________________

MEMBER ID: _____________________________________ GROUP ID: __________________________

Financial Policy and Signature on File

I authorize the release of any medical information to my primary care/referring physician, to consultants, if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of benefits to GPET ALLIED HEALTH AND SERVICES LLC.

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I understand that I am financially responsible for all services rendered and for the following reasons:

1) I do not have the proper referral at the time of service.
2) My referral is invalid/expired.
3) I have given incorrect/invalid insurance information.
4) Expenses are not covered by my insurance company.
5) I have not met my deductible.
6) The services rendered are deemed medically unnecessary by my insurance company.

(This applies to present and future visits).

Patient or Responsible Party:

Signature_______________________________________ Date_______________

IF INFORMATION PROVIDED IS NOT ACCURATE AND CURRENT, WE WILL BE UNABLE TO PROCESS YOUR INSURANCE CLAIM. ANY OUTSTANDING CHARGES WILL BE YOUR RESPONSIBILITY.