Henrike B. Kroemer, Ph.D.

INSURANCE INFORMATION FORM

Date completed _____
Pt account _____ (leave blank) Release on file _____ (leave blank)

Patient full name: Last _____ First_____ M.I._____

Address_____
_____
_____

Sex _____ DOB _____ Marital Status_____

Tel #s: home _____ mobile _____ work _____

Email address _____

PRIMARY INSURANCE

Name of Insured: Last _____ First _____ M.I._____

Relation to patient _____ DOB (of insurance holder) _____

Address (if different than patient's address) _____
_____
_____
_____

Name of Insurance Company _____

Contract Number _____ Group Number _____

Additional insurance information
_____
_____
_____

INSURANCE INFORMATION FORM

SECONDARY INSURANCE (if any)

Name of Insured: Last _____ First _____ M.I._____

Relation to patient _____ DOB (of insurance holder) _____

Address (if different than patient's address) _____
_____
_____
_____

Name of Insurance Company _____

Contract Number _____ Group Number _____

Additional insurance information
_____
_____
_____

IT IS IMPORTANT THAT YOU SIGN BELOW IF YOU WANT DR. KROEMER TO BILL YOUR INSURANCE FOR HER SERVICES

I certify the information given by me regarding my insurance plans is correct to the best of my knowledge. I authorize release of any records required and request payment of authorized benefits be made on my behalf to Dr. Kroemer. I agree that I am responsible for any charges that may accrue from co-payments, unmet deductibles, or any non-covered services or charges. I understand that Dr. Kroemer will contract to file insurance claims for me, but assumes no liability in doing so. While Dr. Kroemer will provide assistance to help me obtain insurance benefits, this does not constitute a waiver by Dr. Kroemer of any portion of fees charged. In the unlikely circumstance that any action is brought to enforce this agreement, Dr. Kroemer, if prevails, shall be entitled to any attorney's fees and collection costs.

Authorized Signature_____

Relationship to patient_____