PATIENT INFORMATION: Location: ______________________ **Provider:** ____________________

Name____M/F_____SS#____________________

Street Address ______________________________________ City/State/Zip______________________

TEL# Home_________________ Work______________ DOB____________ Marital Status: S M D DP

Main Complaint:_____________________________ Email:__________________________

PRIMARY INSURANCE INFORMATION: Relationship to insured Self Spouse Child Other (Please circle one)

Ins Co_________________________________Tel#______________________________________

Address____

Insured Name___________________________ M/F_____ Insured's Employer ____________________

Insured DOB___________ Insured SS#:______________ ID# __________________ Group __________

PRIMARY INSURANCE

Effective date ____________ Deductible/Met/How much ______________________________________

Additional comments ____

____

____

Spoke to: _______________________ Verified by/Date:_______________________________________

SECONDARY INSURANCE INFORMATION: Relationship to insured Self Spouse Child Other (Please circle one)

Ins Co_________________________________Tel#______________________________________

Address____

Insured Name___________________________ M/F_____ Insured's Employer ____________________

Insured DOB___________ Insured SS#:______________ ID# __________________ Group __________

SECONDARY INSURANCE

Additional comments ____

____

____

Wolf Moon Inc

Date:______________________

If patient can not pay copay, coinsurance or deductible:

I ______________________________(patient name) am covered by ________________________ (insurance company) and due to my financial status I am unable to pay Wolf Moon Inc the copay and/or coinsurance and/or deductible.

If patient has no insurance:

I __________________________ (patient name) do not have any medical insurance and due to my financial status I am unable to pay the practice, Wolf Moon Inc the regular fee.

I agree to pay according to the terms listed below:

Signed: ____

Witnessed: _____________________________________

Please note that it is required by Federal Law:42U.S.C 1320a-7(b) and 42U.S.C 1320a-7(b)(6)(B) that the office has you sign this form. We appreciate your cooperation. Thank you.