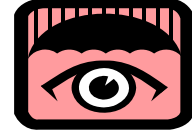




Health Insurance Information Form



Health Insurance Company Information (Primary Insurance)

Company Name _____ Phone # _____
Address _____ City _____ State ____ Zip _____

Insured

Last _____ First _____ MI ____ DOB ____/____/____ Sex ____
Street _____ City _____ State ____ Zip ____
ID# _____ Group # _____ Patient's Relationship to Insured _____
Policy Effective Date: ____/____/____ Employer/School _____
Copay: _____ Deductible: In Network _____ Out of Network _____

Health Insurance Company Information (Secondary Insurance)

Company Name _____ Phone # _____
Address _____
City _____ State ____ Zip _____

Insured

Last _____ First _____ MI ____ DOB ____/____/____ Sex ____
Street _____ City _____ State ____ Zip ____
ID# _____ Group # _____ Patient's Relationship to Insured _____
Policy Effective Date: ____/____/____ Employer/School _____
Copay ____ Deductible: In Network _____ Out of Network _____

Insurance Assignment & Release

I, the undersigned, have insurance coverage with: _____

And assign directly to Charles S. Hill, M.D. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian

Date

MEDICARE Authorization:

I request that payment of authorized Medicare benefits be made on my behalf to Charles S. Hill, M.D. for any service furnished me by the physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other" health insurance is indicated in item 9 of the HCFA - 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature

Date