Patrick H. Waring, M.D., LLC

Insurance Information

Primary Insurance

Insurance Co: _____

Group Number:_____

Member/ID Number: _____

Relationship to Insured:_____

Insured's Name:_____

Date of Birth:_____

Secondary Insurance

Insurance Co: _____

Group Number:_____

Member/ID Number: _____

Relationship to Insured:_____

Insured's Name:_____

Date of Birth:_____

Date of Injury / Accident:

_____

Workers Comp Information:

_____

Company

_____

Address / Phone

I hereby authorize the above listed insurance companies to pay directly to Patrick H. Waring, MD, LLC and The Pain Intervention Center, LLC, benefits due me, if any, as provided in the above un-expired policy. I will pay all charges in excess of whatever sums may be paid. I authorize Patrick H. Waring, MD, LLC, and The Pain Intervention Center, LLC, to release information to the insurance company for my claims to be paid. Please attach copy of insurance card. If payment is not made timely, and the account is turned over to an attorney-directed collection service, I will pay all attorney fees associated with the collection of all balances due.

I hereby acknowledge that I have been provided a copy of the HIPPA Privacy Practice.

Patient Signature_____ Date _____