INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Co. ______________________

Group Number ______________________

Member/ID # ______________________

Relationship to Insured ______________

Insured's Name ______________________

Date of Birth ______________________

SECONDARY INSURANCE

Insurance Co. ______________________

Group Number ______________________

Member/ID # ______________________

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 ______________