Insurance Information

Patient Name: _____Date: _____

Patient's Social Security Number: _____

Primary Insurance: _____Policy #:_____

If the primary insurance is in the name of someone other than the patient, we need the following:

Name of Insured: _____

Social Security #: _____ DOB: _____

Secondary Insurance: _____ Policy #: _____

If the secondary insurance is in the name of someone other than the patient, we need the following:

Name of Insured: _____

Social Security #: _____ DOB: _____

Patient Authorization

Insurance Lifetime Authorization: I request that payment of my insurance benefits be made to Lisa Kay Mao, M.D. I authorize medical information be released to the insurance company to determine these benefits for services.

Fee Consent: I assume full financial responsibility for all services provided by Lisa Kay Mao, M.D.

Patient's Signature: _____

Witness: _____ Date: _____

PLEASE HAVE YOUR INSURANCE CARD READY FOR US TO MAKE A COPY .