Huneycutt Family Medicine

Patient Insurance Form

Insurance is a way for you to receive repayment for fees you have paid to a physician for services rendered. Having insurance is not a substitute for payment. Even though insurance companies have a fixed allowance or percentage based on your policy with them, your policy is with your insurance company, not with this office. It is your responsibility to provide payment for the deductible, co-insurance, and any other balances not paid for by your insurance. We will assist you in receiving reimbursement in any way possible, but you are ultimately responsible for the payment of your bill.

Primary Insurance: _____ Effective Date: _____

Address: _____ City/State/Zip: _____

Policy #: _____ Group #: _____ Phone #: _____

Insured: _____ DOB: _____ Relationship to Insured: _____

Secondary Company: _____ Effective Date: _____

Address: _____ City/State/Zip: _____

Policy #: _____ Group #: _____ Phone #: _____

Insured: _____ DOB: _____ Relationship to Insured: _____

Medicare Patients

I request that payment of authorized Medicare benefits be made to me or on my behalf to Steven Huneycutt, M.D. for any services furnished me by Steven G. Huneycutt MD, FAAFP. I authorize that any holder of medical records about me to release to the Health Care Financing Administration and its agents any information necessary to determine benefits and process the insurance claim. This agreement will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original.

Non-Medicare Patients

I authorize the release of all medical records needed to process this claim and that is pertinent to my medical care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, to Steven Huneycutt, M.D.. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I ASSUME FINANCIAL RESPONSIBILITY FOR ALL CHARGES. I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND IT.

Patient:

_____ _____

(If patient is a minor, a parent's signature is required) (responsible party)

_____ _____

(witness) (date)