FRASER CENTER

Financial Information

CLIENT NAME: ____
(Last) (First) (MI)

MALE [ ] FEMALE [ ] BIRTHDATE __________________ SS# _________________________

HOME PHONE: ________________________ WORK PHONE: _______________________

ADDRESS:____

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EMPLOYER: ____

ADDRESS: ____

PHONE: _____________________________

Who is responsible for the cost of your treatment at FRASER CENTER? (If not yourself, please give responsible person's name, address and phone number)

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PRIMARY INSURANCE

INSURANCE COMPANY: ____

PHONE NO.: ___________________________

NAME OF INSURED: ___________________________________ DOB: ________________

POLICY NO.: _______________________ GROUP NO.: ____________________________

SECONDARY INSURANCE

INSURANCE COMPANY: ____

PHONE NO.: ___________________________

NAME OF INSURED: ___________________________________

POLICY NO.: _______________________ GROUP NO.: ______________________

Do you have TRICARE? __________ If yes, rank of service member: __________ ETS date: ________

I hereby authorize the release of any information acquired in the course of my treatment to my insurance company.

I hereby authorize payment directly to the Fraser Center for my insurance benefits, if any, otherwise payable to me for services rendered.

I permit a copy of this authorization to be used in place of the original.

Signature: ____________________________________ Date: ____________________

PLEASE NOTE: If you have insurance coverage, please understand that this is an agreement between you and you insurance company. You are responsible for the payment of your bill regardless of the status of your insurance claim. We will be glad to help you in submitting your insurance claims for prompt reimbursement.