Bloomsburg UNIVERSITY

Speech, Language and Hearing Clinic

Patient Insurance Information

Release Authorization

Patient Name: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Birth date: ____/____/_____ Sex: M F Social Security #: _____

Referred by: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Month/Year Last Seen by Primary Care Physician: _____/_____

If under 18, please list the employer of one parent: _____

Primary Health Insurance:

Insurance Co. Name: _____

ID #: _____

Group #: _____

Subscriber's Name: _____

Relationship: _____

Address: _____

_____

Phone # (on back of card): _____

Secondary Health Insurance:

Insurance Co. Name: _____

ID #: _____

Group #: _____

Subscriber's Name: _____

Relationship: _____

Address: _____

_____

Phone # (on back of card): _____

For Accident-Related Claims Only: WORK AUTO OTHER _____

Send bills to: _____

Where did accident happen? _____

I, the undersigned, hereby grant permission to release my medical information and authorize payment of benefits to the Bloomsburg University Speech, Language and Hearing Clinic. I also understand that I am fully responsible for payment of DEDUCTIBLES AND CO-PAYMENTS and any changes that are incurred and not covered by my insurance. MEDICARE PATIENTS: "I request that payment of authorized Medicare benefits be made either to me, or on my behalf to the Bloomsburg University Speech and Hearing Clinic for any services furnished me by physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits and payment for related services." SHOULD THIS ACCOUNT GO TO COLLECTIONS FOR NON-PAYMENT, THE PATIENT/GUARANTOR ACCEPTS RESPONSIBILITY FOR ALL COLLECTION FEES.

Signature: _____ **Date:** _____

Centennial Hall • Bloomsburg University • 400 East Second Street • Bloomsburg, PA 17815
Phone: (570) 389 – 5380 • Fax: (570) 389 – 5022
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