



INSURANCE INFORMATION

Please complete insurance information below and provide copies of primary and secondary insurance cards to front office staff.

Primary Insurance

Subscriber's Name: _____ Date of Birth: _____
Subscribers SS# _____ Relationship to patient: _____
Insurance Name: _____ Subscriber ID# _____ Group# _____
Employer: _____

Secondary Insurance: Yes / No

Subscriber's Name: _____ Date of Birth: _____
Subscribers SS# _____ Relationship to patient: _____
Insurance Name: _____ Subscriber ID# _____ Group# _____
Employer: _____

Release Authorization

I hereby authorize Atlas Medical Consultants to release any and all medical information to the above named insurance carrier (or to a designated attorney) for purposes of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of aligning until revoked in writing. I understand that I may request a copy of this authorization; I have read this authorization and understand it. I HEREBY AUTHORIZE ALL INSURANCE BENEFITS MADE PAYABLE DIRECTLY TO ATLAS MEDICAL CONSULTANTS, FOR SERVICES RENDERED. I understand I am financially responsible to said doctor(s) for charges whether or not covered by this assignment. I further agree in the event of non-payment, to bear the cost of collection, and reasonable legal fees should this be required.

Authorization For Medical Treatment

I hereby give permission to the staff of Atlas Medical Consultants to administer any treatment that may be deemed necessary or advisable in the diagnosis and treatment of my/my dependent's condition.
