



Patient Billing Information Form
Randy Weinreb, LMT, LAC

\_\_\_\_ New Patient
\_\_\_\_ Est. Pt. Data Change

Patient Name: \_\_\_\_\_ Sex: Male ( ) Female ( )

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Marital Status: \_\_\_ M \_\_\_ S \_\_\_ W \_\_\_ D Social Security: \_\_\_\_\_

Employer Name & Address: \_\_\_\_\_

\_\_\_\_ Employer Phone: \_\_\_\_\_

Insurance Type: \_\_\_ Medicare/Medicaid \_\_\_ Major med/Group Health \_\_\_ Personal Injury
\_\_\_ WorkersComp

Claims Sending Address: \_\_\_\_\_

Insurance Phone Number: \_\_\_\_\_

Name of Person Insured: \_\_\_\_\_ Date of Birth of Insured: \_\_\_\_\_

Patient Relationship to insured: \_\_\_ SELF \_\_\_ Spouse \_\_\_ Child \_\_\_ Other: \_\_\_\_\_

Insurance ID#: \_\_\_\_\_ Insurance Group #: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Name of Insured's Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Is your condition due to an accident: \_\_\_ Yes \_\_\_ No Date of Accident? \_\_\_\_\_

State accident occurred in \_\_\_\_\_ Work Related ( ) Automobile Related ( ) Other ( )

Adjustor Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Please be Advised that this office is NOT contracted with Medicare/Medicaid.

I \_\_\_\_\_ clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I agree to allow Randy Weinreb, LMT, LAC to bill my insurance company as a courtesy, permit the release of medical records necessary to process my claims, and authorize payments to be made directly to Randy Weinreb, LMT, LAC for treatment rendered. I further understand that co-payments are due at the time of service and that I may be billed for charges not covered by my insurance company.

\_\_\_\_ Patient Signature \_\_\_\_\_ Date