*VITTORIA HEALING ARTS*

**INSURANCE INFORMATION FORM (for HEALTH INSURANCE CLAIMS)**

Full name (as listed on Insurance policy): _____

Date of Birth: _____ Phone #: _____

Address: _____

City: _____ State:_____ Zip: _____

Name of Insurance Company: _____ Insurance Provider Ph.#:_____

Member I.D. #: _____ Group #: _____

Name of Employer: _____

Areas of main concern: _____

Name of Primary Care Dr. or Referring Physician/Chiropractor: _____

**Please fill out the following information if the primary insurer is someone other than yourself:**

Primary Insurer's Full name: _____

Date of birth: _____ Phone #: _____

Address: _____

City: _____ State: _____ Zip: _____

Your relation to insured? Spouse Partner Child Other

**Client Agreement**

Once your insurance coverage has been verified, we will be glad to bill directly to and accept payment from your insurance company for covered services. Your signature below confirms that it is your responsibility to pay for all services provided. In the event the insurance company denies payment or makes partial payment, you are responsible for the balance, deductibles, and copays.

**Assignment of Benefits**

Your signature below authorizes and directs payment of medical benefits directly to Vittoria Healing Arts (aka Kelly Vittoria) for services provided at this office.

**Release of Medical Records**

Your signature below authorizes the release of all your medical records on file in this office to your attorneys, health care providers, and insurance case managers, for the purpose of processing your claims, unless otherwise stated in an exclusive release of medical records signed through your attorney.

_____

Signature Date

_____

Signature of parent or legal guardian (if client is a minor) Date