Clearwater Family Medicine & Dental

214 W Washington Ave, Suite 300, Madison, WI 53703 · (608) 555-0136 · Fax (608) 555-0137

BILLING & FINANCIAL POLICY

Insurance & Payment Authorization

PATIENT & POLICYHOLDER

PATIENT NAME _____ DATE OF BIRTH _____

POLICYHOLDER NAME (IF NOT PATIENT) _____ RELATIONSHIP TO PATIENT _____

PRIMARY INSURANCE

CARRIER _____ MEMBER ID _____ GROUP # _____

SECONDARY INSURANCE (OPTIONAL)

CARRIER _____ MEMBER ID _____ GROUP # _____

ASSIGNMENT OF BENEFITS

I authorize Clearwater Family Medicine & Dental to release medical and billing information needed to process insurance claims, and I authorize payment of medical benefits directly to the clinic for services rendered. I understand that I am responsible for any deductible, copay, coinsurance, or non-covered service, and that an itemized Good Faith Estimate is available on request before treatment for self-pay care.

PAYMENT METHOD ON FILE (OPTIONAL)

☐ Card on file for copay/coinsurance only ☐ Bill me by mail ☐ Self-pay, prompt-pay discount requested

POLICYHOLDER SIGNATURE _____ DATE _____