Roseann Lynch.

1621 Tongass Avenue, Suite 305, Ketchikan AK 99901

Client Primary Insurance Information

Patient Name				**Patient Date of Birth**	**Marital Status (Please Circle one)** **Married Single Other**	**Gender**
Patient Physical Address		**Patient Mailing Address**			**Patient Phone Number(s)** **HM:** **CELL:**	
Primary Insurance Company		**Primary Insurance Address**			**Insurance Company Phone Number**	
Insurance Policy Number		**Insurance Group Number (if Any)**			**PATIENT SSN**	
Deductible Amount	**Has Deductible been met?** **Yes No**	**Is there a Co-pay?** **Yes No**	**Co-pay amount**		**Insured SSN (if different from pt)**	
Insured's Name (Last, First, MI)				**Insured's DOB**	**Relationship to Patient**	

SECONDARY Insurance Information

Patient Name				**Patient Date of Birth**	**Marital Status (Please Circle one)** **Married Single Other**	**Gender**
Patient Physical Address		**Patient Mailing Address**			**Patient Phone Number**	
SECONDARY Insurance Company		**SECONDARY Insurance Address**			**Insurance Company Phone Number**	
Insurance Policy Number		**Insurance Group Number (if Any)**			**Insured SSN**	
Deductible Amount	**Has Deductible been met?** **Yes No**	**Is there a Co-pay?** **Yes No**	**Co-pay amount**		**Relationship to Patient**	
Insured's Name (Last, First, MI)				**Insured's DOB**	**Insured's Employer**	

I agree that by signing below I am allowing my insurance to be billed and to be paid directly to provider. I except full financial responsibility for all unpaid balances for the patient name listed above. This includes, but is not limited to collection fees, interest, and attorney fees.

______________________________ ______________________________ __________

PRINT NAME SIGNATURE DATE