The Carolina Hand Center

INSURANCE INFORMATION

Primary Insurance Company ____________________

Policy Number ____________ Group Number ____________ Certificate Number ____________

Policy Holder's Name ____________________

Policy Holder's Employer ____________________

Policy Holder's SSN # ________ - ________ - ________ Birth Date ____________

Insured's Relationship to Patient ____________________

Secondary Insurance Company ____________________

Policy Number ____________ Group Number ____________ Certificate Number ____________

Policy Holder's Name ____________________

Policy Holder's Employer ____________________

Policy Holder's SSN # ________ - ________ - ________ Birth Date ____________

Insured's Relationship to Patient ____________________

PLEASE READ CAREFULLY

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, YOU are responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when treatment is rendered unless prior arrangements have been made. **If your account is not paid, you will be responsible for any fees incurred in the collection of your balance.**

I hereby, assign to THE CAROLINA HAND CENTER, P.C. all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. **I grant CHC permission to file an appeal process on my behalf should any claims be denied by my insurance carrier.**

I understand that return visits will be scheduled based on my medical condition and that it is my responsibility to keep these appointments, or call in advance to reschedule.

Patient Signature: ____________________

Date: ____________________

Guarantor Signature: ____________________

Date: ____________________

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