2019

Athans and Associates, Ltd.
32 Main Street, Park Ridge, IL 60068
Tel: (847) 823-4444

#2/5

INSURANCE RELEASE

☐ ***Insurance waiver:*** I will **NOT** be using insurance. _____ _____
Signature *Date*

If you are using insurance as a form of payment, please fill out completely. This information is necessary in order for us to file an insurance claim on your behalf. Failure to provide complete information may result in denied claims.

Patient Name: _____ Patient DOB:____/_____/_____
Relationship to Insured: ☐ Self ☐ Child ☐ Spouse ☐ Legal Guardian

The Following Information Pertains to the Person Providing the Insurance

POLICY HOLDER NAME: _____ DOB: ____/____/____
Address: _____ City: _____ State: _____ Zip: _____
Soc Sec #: _____/_____/_____
Home Phone # (_____)_____ Work Phone # (_____)_____
Employer: _____
Employer Address: _____ City: _____State: ____ Zip: _____

Primary Insurance:_____
Group #: _____ Policy #: _____
Claims Address: _____City: _____
State: _____ Zip: _____ Phone #: (____)_____
Electronic Claims #: _____
Type of Coverage: ☐ Single ☐Family Deductible Amt: $ _____ Met For This Year? ☐Yes ☐No
Type of Plan: ☐PPO/POS ☐EAP ☐HMO Is Pre-certification Required? ☐Yes ☐No; if so;
Authorization #: _____ Copay: $ _____
****Note: It is the patient's responsibility to procure the initial authorization. We make every effort to maintain all of our staff on a comprehensive list of insurance panels listed below. We cannot always guarantee accuracy, however, due to constant changes in the industry. We ask that you verify your benefits and that we are listed on your plan through your insurance company.*

Is the patient currently being treated, or been treated in the last 12 months for the same or similar condition? ☐Yes ☐ No; If yes, please list providers and dates of onset of treatment _____
_____

I authorize the release of any information necessary to process this claim. I also authorize the payment of benefits directly to the above- named supplier who accepts assignment. It is understood that the undersigned has the responsibility for payment of services. Assignment of benefits does not release the undersigned from responsibility for payment. If this release is not signed you will be asked for full payment at time of service. This release is valid through: _____/_____/_____.

_____ _____ _____
Patient/Guardian Signature Date Witness Signature