GREGG T. PODLESKI, D.O.

ORTHOPEDIC SURGERY • SPORTS MEDICINE • BOARD CERTIFIED

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INSURANCE INFORMATION

PRIMARY INSURANCE

CARRIER ____ PHONE _____________________________

PATIENT ID ____ GROUP # ___________________________

CLAIMS ADDRESS ____

CITY ____ ST ___________ ZIP _______________

PRIMARY INSURED PERSON → SELF PARENT SPOUSE

PRIMARY INSURED'S D.O.B. ___________________ SOCIAL SEC # _________________________________

SECONDARY INSURANCE

CARRIER ____ PHONE _____________________________

PATIENT ID ____ GROUP # ___________________________

CLAIMS ADDRESS ____

CITY ____ ST ____________ ZIP _______________

SECONDARY INSURED PERSON → SELF PARENT SPOUSE

SECONDARY INSURED'S D.O.B. ___________________ SOCIAL SEC # ______________________________

WORKER'S COMPENSATION

CARRIER ____ PHONE _____________________________

ADJUSTER ____ FAX _______________________________

CARRIER ADDRESS____

CITY ____ ST ____________ ZIP _______________

DATE OF INJURY _____________________________ CLAIM # ____

EMPLOYER __________________________________ OCCUPATION ____________________________________

EMPLOYER ADDRESS____

CITY ____ ST ____________ ZIP _______________

PHONE ____________________________________ FAX ____

THE ABOVE INFORMATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE DR. GREGG T. PODLESKI D.O. TO FURNISH MY INSURANCE COMPANY(S) WITH ANY INFORMATION DESIRED CONCERNING MY: HISTORY, FINDINGS, DIAGNOSIS AND TREATMENT RENDERED TO ME. I ALSO AUTHORIZE MY INSURANCE COMPANY(S) TO PAY DR. GREGG T. PODLESKI D.O. DIRECTLY. AS THE PATIENT I ACCEPT AND UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANY COPAY, DEDUCTABLE OR COINSURANCE THAT MY INSURANCE COMPANY DEEMS TO BE MY PORTION. I ALSO CERTIFY THAT THE PRE-EXISTING CLAUSE, IF ANY, ON MY POLICY DOES NOT APPLY TO MY CIRCUMSTANCE IN ANY WAY AND IF FOUND OTHERWISE I AM FULLY AWARE THAT I WILL BE RESPONSIBLE FOR ALL PROCEDURE CHARGES.

SIGNATURE ____ **DATE** __________________________

OTHER RESPONSIBLE PARTIES SIGNATURE _________________________________ **RELATIONSHIP TO PATIENT** ________________

Revised 1-3-2011