CHANGE OF INSURANCE

PEBBLECREEK MEDICAL GROUP

PATIENT NAME: _____

Primacy Insurance Company _____

Ins. Address _____ Phone _____
City State Zip

ID/Policy# _____ Group# _____

Policy Holder's Name _____ Relationship to Patient _____ Date of Birth _____

Policy Holder's Employer: _____ Phone _____ SS# _____

Emp.Address _____
City State Zip

Secondary Insurance Company _____

Ins. Address _____
City State Zip

ID/Policy # _____ Group# _____

Policy Holder's Name _____ Relationship to Patient _____ Date of Birth _____

Policy Holder's Employer: _____ Phone _____ SS# _____

Emp. Address _____
City State Zip

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize payments of medical benefits to the provider for services, rendered or to rendered in the future, without obtaining my signature on each claim submitted., and the signature will bind me as though I personally signed the claim. I also authorize the release of any medical information necessary. **I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES**. If this account should be referred to a collection agency, I will be responsible for any collection and /or legal fees. I have read and understand the office policy and procedures.

_____ _____
Responsible Party Signature Date