INSURANCE INFORMATION

☐Mr. ☐Mrs. ☐Ms. ☐Miss	First Name	Middle Name	Last Name

Do you have health insurance? ☐ Yes ☐ No

Who is responsible for this account?

☐ Self ☐ Other (Specify)________________________________ Relationship to Patient:_______________

Do you have a Co-Pay? ☐ Yes ☐ No Amount for Specialist: $_______________

Primary Insurance Name:	Secondary Insurance Name:
Billing address of Primary Insurance:	Billing address of Secondary Insurance:
Insured name on ID card:	Insured name on ID card:
Member ID Number:	Member ID Number:
Group Number:	Group Number:

Does your insurance company require a referral from your primary physician to see a specialist?

☐ Yes ☐ No

If Yes, you will be responsible to obtain one from your primary care physician. If your insurance company denies claim due to no referral, *you will be responsible for the balance of the claim*.

Assignment of Insurance Benefits

I hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents, I further expressively agree and acknowledge that my signature on this document authorizes *Dr. David S. Chung* to submit claims for benefits, for services rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by my signature as though I had personally signed the particular claim.

I instruct my insurance or other benefits provider to pay *Dr. Chung* directly for all professional and medical services provided by *Dr. Chung*. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to *Dr. Chung* will be credited to my account, in accordance with the above said assignment.

Patient Signature: ____ Date: _______________________