

P: 616-772-9358

T: 800-864-0293

F: 616-772-9368

**Patient Information**

Name	Male	Female
Date of Birth	Soc.Sec #	
Physical Address		
City, State, Zip		
Home phone	Best time to reach you	am pm
Alternate/Cell phone		
Email Address		
May we leave a message on your voice mail?	Yes No	May we contact you by e-mail? Yes No

**THIS SECTION MUST BE COMPLETED**

Is your claim related to:    Workers Comp? Yes No                      Auto Accident? Yes No                      Liability? Yes No  
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 If yes, be sure to include complete Group Health Insurance information in full.

**Work Comp/Auto/Liability Insurance Carrier Information**

Insurance Company	
Address	
City, State, Zip	
Phone/Extension	Adjuster Name
Date of Accident/Injury:	Claim #:

**Primary Group Health Insurance**

Insurance Company		
Address		
City, State, Zip		
Phone/Extension	Id number on card	Group #
Subscriber name	Subscribers Date of Birth	
Relationship to patient	Self	Spouse Child Other

**Secondary Group Health Insurance**

Insurance Company		
Address		
City, State, Zip		
Phone/Extension	Id number on card	Group #
Subscriber name	Subscribers Date of Birth	
Relationship to patient	Self	Spouse Child Other

**Assignment of Insurance Benefits and Release**

I, the undersigned, certify that I, or my dependent, have insurance coverage with the insurance carrier(s) listed above assign directly to Advanced Therapy Concepts, Inc all insurance benefits, otherwise payable to me, for services rendered I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Advanced Therapy Concepts, Inc to release any and all information necessary to secure payment of benefits by my insurance carrier(s). I authorize the use of this signature on all insurance submissions.

Responsible party signature	Relationship to patient	Date
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