

Secondary Coverage

Insurance Information

SECONDARY INSURANCE COMPANY _____

POLICY OWNER'S NAME _____

POLICY OWNER'S PLACE OF EMPLOYMENT _____

INSURANCE ID NUMBER _____

EFFECTIVE DATE

GROUP NUMBER _____

_____/_____/_____

INSURANCE ADDRESS _____

Street

City

State

Zip

TELEPHONE NUMBER(____) _____

RELATIONSHIP TO PATIENT Self Spouse Parent
(Circle One) Step-Child Other _____

Important Patient Information & Authorization

In order to keep costs down, the physician sees patients on a fee for service basis only, and we expect payment at the time of service. We try to assist you in submitting your insurance claims by providing you with a detailed receipt form at the end of each visit that contains all the information needed from the doctor for your insurance company to process your claim.

Valley Health Center requires 24-hours notice of cancellation if an appointment needs to be changed so that we may provide appointment time for patients who need it. There will be a \$50.00 charge for missed appointments.

I authorize Valley Health Center to release any information to my insurance carriers concerning my medical treatments. I also authorize payment to be made directly to Valley Health Center if not already paid in full by the insured. Valley Health Center reserves the right to charge 2% interest per month on any unpaid balance.

I hereby certify to the above statements and agree to be financially responsible for any payments not covered by insurance.

SIGNED: _____

DATE: ____/____/____