# *Patient Insurance Information*


**Patient Information**

*Last Name* *First Name* *Middle Initial* *Birth date*

**Guarantor/ Insurance Policyholder Information**

*Last Name* *First Name* *Middle Initial* *Birth date*

*Mailing Address:* *(house #, street, PO box, Lot #, Apt #)*

*City* *State* *Zip Code*

*Home Phone#*

*What is the relationship of the **patient** to the Guarantor/Policyholder?*
*Self* *Spouse* *Child* *Other*_____

**Primary Insurance**

*Insurance Company Name*

*Address* *City* *State* *Zip Code*

*Telephone #*

*Policy#* *Group#*

**Secondary Insurance**

*Insurance Company Name*

*Address* *City* *State* *Zip Code*

*Telephone #*

*Policy#* *Group#*

I understand that I am ultimately financially responsible for all charges for services rendered by Evergreen Neurosurgery Center to the patient listed above. If my insurance coverage is under a plan in which Evergreen Neurosurgery Center does participate, including Medicare, I agree that I am responsible for all deductibles, copays, coinsurance payments and denied charges unless limited by insurance contracts or state or federal law.

I further understand that, with the exception of Medicare and Medicaid, Evergreen Neurosurgery Center is not obligated to file claims on my behalf and is doing so as a courtesy.

Patient Name:_____

Patient Signature:_____ Date:_____
(Parent/Guardian if patient is a minor)

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