INSURANCE INFORMATION

PRIMARY

INSURANCE CO. NAME: _____

IF GROUP INSURANCE, NAME OF EMPLOYER: _____

INSURED'S NAME (AS IT APPEARS ON CARD) : _____

INSURED'S RELATIONSHIP TO PATIENT: _____

INSURED'S SOCIAL SECURITY NUMBER: _____

INSURED'S DATE OF BIRTH: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

SECONDARY

INSURANCE CO. NAME: _____

IF GROUP INSURANCE, NAME OF EMPLOYER: _____

INSURED'S NAME (AS IT APPEARS ON CARD) : _____

INSURED'S RELATIONSHIP TO PATIENT: _____

INSURED'S SOCIAL SECURITY NUMBER: _____

INSURED'S DATE OF BIRTH: _____

IF ACCIDENT, TYPE: _____

DATE OF ACCIDENT: _____

LIFETIME MEDICARE "B" SIGNATURE AUTHORIZATION

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or it's intermediaries or carriers, or to the billing agent of Patrick M. Kelley, M.D., any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request that payment of medical insurance benefits be made either to myself or to the party who accepts assignment.

PATIENT'S SIGNATURE: _____

REASON IF PATIENT UNABLE TO SIGN: _____

RELATIONSHIP TO PATIENT: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Dr. Patrick M. Kelley to furnish information to the insurance carriers concerning my illness and treatments and I hereby assign to the physician all payments for medical services rendered to me or my dependents. I understand that I am responsible for any amount not covered by my insurance.

DATE: _____ SIGNATURE: _____