June E. Kramer, M.D.
Psychiatry

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INSURANCE INFORMATION

Name: ____

Subscriber/Guarantor Name: ____

Address: _________________________ City: _______________ Zip Code: ________

Subscriber's Social Security Number:____________________

Subscriber's Date of Birth: __________________ Name of insurance ______________________

Insurance ID number_______________________Group number_________________________

I will make a copy of your insurance card in order to have the information I need to bill. Please also sign the agreement below, giving me permission to release limited information about you to your insurance company. This is required by them to process claims.

AGREEMENT

I hereby authorize my insurance benefits be paid directly to June E. Kramer, M.D., and I am financially responsible for non-covered services. I also authorize Dr. Kramer to release any information required to process this claim or to obtain authorization for services. I understand that my records may contain information regarding drug/alcohol abuse, sexually transmitted diseases, treatment of HIV (AIDS virus), mental illness, and/or psychiatric treatment. I give my specific authorization for these records to be released to any person or corporation which is or may be liable under a contract with Dr. Kramer or the patient. This consent, with respect to the conditions noted above, shall be effective only so long as reasonably necessary to obtain reimbursement.

Date: __________________

Signature: __________________________

Relationship to Patient: ________________

Witness: ___________________________