

**Insurance Information**

Amy L. Offutt, MD/Dana Bourke, NP

Patients Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
                            First                    Middle                    Last

Primary Insurance: \_\_\_\_\_

Subscribers Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ SS# \_\_\_\_\_

Group # \_\_\_\_\_ Policy/ID #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy/ID #: \_\_\_\_\_

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: \_\_\_\_\_ Relationship: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Contact #: \_\_\_\_\_  
                            Street/P.O. Box City State Zip

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ SS# \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
                            Street/P.O. Box City State Zip

Our office will file insurance for all reimbursable services to your primary insurance and secondary insurance carriers. Please remember that you are responsible for all deductible, co pay, and non-covered service amounts at time of service. Additionally, please be reminded that you agree to notify us of any change in insurance before any services are provided. I understand that Amy L Offutt, MD, PA and Dana Bourke, NP, may not be a participating physician in my commercial insurance plan; therefore, I am responsible for total charges for services rendered. I agree that should account become delinquent, I am responsible for reasonable attorney or collection expenses. This office **does not** accept **Medicaid, Aetna HMO, Humana, EPO or United Healthcare insurance**; please be sure to check with your insurance carrier to see if you are covered at this establishment.

**Assignment of Benefits**

I hereby assign to Amy L Offutt, MD, PA and/or Dana Bourke, NP, and insurance or other third party benefits available for health care services provided to me. I understand that Amy L Offutt, MD, PA and/or Dana Bourke, NP has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Amy L. Offutt, MD, PA and/or Dana Bourke, NP, I agree to forwards all health insurance or third party payment that I receive for services rendered to me immediately upon receipt.

I authorize the release of any medical information necessary to process my claim.

I authorize payment of medical and /or surgical benefits to Amy L Offutt, MD, and Dana Bourke, NP.

\_\_\_\_\_ Date: \_\_\_\_\_  
Signature of patient or responsible party