# Insurance Signature on File

Patients Name: _____ DOB: _____

**Insurance Coverage**

I request that payment of authorized Commercial Benefits, Medicare, or Secondary Medicare coverage benefits be made directly to Iris Family Support Center for any services furnished to me by that provider of service. I understand that I am financially responsible for charges not covered by this authorization. I authorize any holder of medical information to release to my insurance company or its agents any information, which may be necessary to determine benefits payable for related services.

_____ _____

Primary Identification # / Group # Policy Holder (Guarantor Name)

Primary Insurance Policy Holder (Guarantor) Date of Birth

_____ _____

Secondary Identification # / Group # Policy Holder (Guarantor Name)

_____ _____

Secondary Insurance Policy Holder (Guarantor) Date of Birth

_____ _____

Signature of Patient (Parent if patient is a minor) Date