Michigan TCM Wellness Center
INSURANCE FORM

Patient Name *(Last, First):* ____ DOB: ____________ Gender: M / F

Is visit related to accident? Yes / No If so, Date/Place: __________________________Was accident work related? Y / N

Worker's Compensation or Automobile PIP
Carrier/Address:____

Claim#: ___________________ Attorney Name: ________________________________ Phone: __________________

Attorney Address: ____Fax: ____________________

Primary Health Insurance
Insured's Name *(May be different than patient name) (Last, First)*:____

Relationship to Patient: ____ DOB: _________________ Gender: M / F

Address: ______________________________________City: __________________ State: _______ Zip: _____________

Tel/Home: ________________________ Tel/Cell: ________________________ Tel/Work: ________________________

Employer Name/Address: ____

Insurance Carrier/Address: ____ Tel: ____________________

Subscriber ID#: ____ Group #: _____________________________

Secondary Insurance (If Applicable)
Insured's Name *(May be different than patient name) (Last, First)*:____

Relationship to Patient: ____ DOB: _________________ Gender: M / F

Address: ______________________________________City: __________________ State: _______ Zip: _____________

Tel/Home: ________________________ Tel/Cell: ________________________ Tel/Work: ________________________

Employer Name/Address: ____

Insurance Carrier/Address: ____ Tel: ____________________

Subscriber ID#: ____ Group #: _____________________________

Assignment of Benefits and Release
I hereby authorize payment directly to Michigan TCM Wellness Center LLC. for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges if insurance does not cover them. I authorize Michigan TCM Wellness Center LLC. to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Submission to insurance companies is not a guarantee of payment. I also understand that the full fee will be charged if I miss an appointment giving less than 48 hours notice. I understand that this missed appointment fee will not be covered by insurance and that I will be responsible for payment.

Patient/Guardian Signature ____ **Date** ________________________

Print Patient Name ____ **Patient DOB** ____________________