BILLING INFORMATION

Patient name _____ Date of birth _____

Primary Insurance _____ ID# _____

Policy holders name _____

Secondary Insurance _____ ID# _____

- Is your visit related to a **work** injury? ☐ YES ☐ NO Date of injury _____

Worker's compensation Insurance Company _____

Claim # _____

Adjuster/Contact name_____

Phone _____

Is there an attorney involved? ☐ YES ☐ NO

If yes, what is the name of the attorney and please include their phone number-

_____

- Is this related to a **Motor Vehicle Accident or Personal Injury**? ☐ YES ☐ NO

Name of Insurance Company _____

Insurance company contact and phone number _____

Date of injury _____ Claim # _____

If **yes** to the above, do you have an attorney involved? ☐ YES ☐ NO

If yes, please provide the name of the attorney and please include their phone number-

_____

Authorization and assignment

I hereby authorize Dr. Shekhar A. Dagam or representative to furnish information to insurance carriers concerning my illness, treatment, and/or hospitalization as needed to process claims. I request payment of authorized benefits be made directly to Shekhar A. Dagam, MD Neurological Surgery SC. These authorizations will remain in effect until I choose to revoke them. I understand that I am financially responsible for all charges not covered or rejected by my medical insurance or workers compensation benefits.

Signature _____ Date _____

Signature of ☐ PATIENT ☐ PARENT ☐ GUARDIAN