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OSTEOPOROSIS DIAGNOSTIC IMAGING AND TREATMENT CENTER

(951) 781-7700 FAX (951) 781-0313

Patient Name _____
Insurance Company_____
Insurance ID # _____
Group ID # _____

_____ understand that I am eligible for insurance benefits under
(Name of Patient)

_____ on or as of _____. This coverage is provided
(Name of Insurance Company) (Date)

by _____, through _____. I understand
(Name of Employer) (Self, Spouse, Parent)

That the above insurance company under which I am covered is responsible for a percentage of all medical services provided to me. The percentage not covered by my insurance company will be paid at the time of service. If I have not met my deductible for the year, I will be responsible for all charges incurred at the time of service until this deductible has been met. I am aware that it is my responsibility to ensure that the Arthritis Medical Clinic has the most current insurance information so that services may be billed properly.

_____
(Signature of patient or responsible party)

_____
(Signature of witness)