sunny days therapeutics

INSURANCE INFORMATION FORM

Name:_____

Date of Birth:_____ Gender: _____

Address:_____

_____

Relationship to the Policyholder: ☐ SELF ☐ OTHERS

If others, please specify:_____

Policyholder's Information

Policyholder's Name:_____

Date of Birth:_____ Gender:_____

Primary Insurance

Insurance Company:_____ Member ID #:_____

Claims Address:_____

Group ID #:_____ Copay:_____

Secondary Insurance (if applicable)

Insurance Company:_____ Member ID #:_____

Group ID #:_____

I acknowledge full financial responsibility for services rendered by Sunny Days Therapeutics, LLC. I authorize the release of all medical records to my insurance company, if applicable. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all attorney fees and collection costs in the event of default of payment of my charges. I further authorize and request that insurance payments be made directly to Sunny Days Therapeutics, LLC should they elect to receive such payment.

Signature:_____ Date:_____