Medical Billing Information and Consent to Services

MIXED INCLUSION

Patient Name: _____

Patient Date of Birth: _____ / _____ / _____

Name of Insured Party: _____

Date of Birth:_____ / _____ / _____

Relationship to Patient: _____

Home Address: _____

City: _____, State _____, Zip_____

Phone Number : (_____) _____ - _____

Email: _____

Employer: _____

Insurance Carrier: _____

Insurance ID #:_____

Insurance Group #:_____

By signing this form, I hereby consent to Mixed Inclusion, LLC. billing insurance for services rendered.

_____ _____

Signature of Insured Party Date