



VCFE of Northern Indiana
 2025 E. Edison Rd., Ste. B,
 South Bend, IN 46637
 574-232-5831

DATE: _____

Patient's Name		Date of Birth	Social Security #
Street Address		Email Address	
City	State	Zip Code	Home Telephone Number
Employee Name		Cell Phone Number	Work Phone Number

PRIMARY INSURANCE INFORMATION

Insurance Company Name	CoPay Amount	Group Name or #	ID #
Insurance Company Claims Address			
City	State	Zip Code	Telephone
Policy Holder's Name (if other than Patient)		Social Security #	Date of Birth
Address			
City	State	Zip Code	Telephone
Policy Holder's Employee		Employer's Group Plan: Yes ___ No ___	

SECONDARY INSURANCE INFORMATION

Insurance Company Name	CoPay Amount	Group Name or #	ID #
Insurance Company Claims Address			
City	State	Zip Code	Telephone
Policy Holder's Name (if other than Patient)		Social Security #	Date of Birth
Address			
City	State	Zip Code	Telephone
Policy Holder's Employer		Employer's Group Plan: Yes ___ No ___	

ADDITIONAL INFORMATION

Emergency Contact Name/Relationship	Home Phone	Work Phone Number	Cell Number
Referring Physician		Family or Primary Care Physician	
Pharmacy Name	Address	Phone Number	

ASSIGNMENT OF BENEFITS & INFORMATION RELEASE:

I hereby assign all medical and/or surgical benefits, to which I am entitled to (fill in office name). This assignment remains in effect until revoked by me in writing. A facsimile or photocopy of this assignment is to be considered valid as an original. I hereby authorize said assignee to release all information necessary to secure payment. I consent to the release of information by (fill in office name) and my health insurance and/or payor to (fill in office name), and its employees/representatives to facilitate peer review and of my treatment including utilization and quality management. I understand that (fill in office name) will maintain the confidentiality of this information at all times.

I understand that I am financially responsible for all charges whether or not paid by said insurance. I understand that my medical insurance is a contract between myself and the insurance company and/or my employer. (fill in office name) is not a party to said contract. I understand that I am responsible for legal and/or collection fees necessary to settle my account, should it become delinquent.

SIGNED: _____

DATE: _____