operantbillingsolutions

Client/Patient Information **APL**

Client/Patient Name:_____
Last First Middle

Client/Patient Date of Birth:_____Gender: ☐ M ☐ F

Mailing Address:_____

City_____State_____Zip_____

Telephone Number:_____

Referring Physician:_____
Last First

Diagnosis Code:_____**5 digit numerical code or 4 digit alphanumeric code *REQUIRED***

Guarantor (Financially Responsible):

Name:_____
Last First Middle

Guarantor Date of Birth:_____Gender: ☐ M ☐ F

Mailing Address:_____

City_____State_____Zip_____

Telephone Number:_____Cell:_____

Email:_____

Signature on file accepting financial responsibility: ☐ Y ☐ N

Primary Insurance Policy Holder:

Name:_____
Last First Middle

Date of Birth:_____Gender: ☐ M ☐ F

SSN:_____(For insurance verification)

Insurance Company:_____

Policy Number:_____Group Number:_____

Signature on file allowing claim to be billed to insurance Company: ☐ Y ☐ N
Date Release Signed:_____

Secondary Insurance Policy Holder:

Name:_____
Last First Middle
Date of Birth:_____Gender: ☐ M ☐ F

SSN:_____(For insurance verification)

Insurance Company:_____

Policy Number:_____Group Number:_____

Signature on file allowing claim to be billed to insurance Company: ☐ Y ☐ N
Date Release Signed:_____

Tertiary Insurance Policy Holder:

Name:_____
Last First Middle
Date of Birth:_____Gender: ☐ M ☐ F

SSN:_____(For insurance verification)

Insurance Company:_____

Policy Number:_____Group Number:_____

Signature on file allowing claim to be billed to insurance Company: ☐ Y ☐ N
Date Release Signed:_____

Document completed by:_____Date:_____
I acknowledge the the above information is correct.