

**INSURANCE INFORMATION**

Brian E. Hass, MD  
Andrea N. Hass, MD

Please fill out the following, or provide current copy(ies) of your insurance card(s)

Name: \_\_\_\_\_

Date of Visit \_\_\_\_\_

Daytime phone # \_\_\_\_\_

Name of Primary Insurance: \_\_\_\_\_

Address: \_\_\_\_\_

ID/Contract #: \_\_\_\_\_ Group #: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of Secondary Insurance: \_\_\_\_\_

Address: \_\_\_\_\_

ID/Contract #: \_\_\_\_\_ Group #: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**IN ORDER TO SUBMIT YOUR VISIT(S) TO INSURANCE, PLEASE SIGN BELOW:**

All questions regarding insurance of fees should be asked prior to services being rendered. Payment is due at the time of your visit unless prior arrangements have been discussed. I hereby authorize the release of any medical information necessary to process my insurance. I hereby authorize payment of medical and/or surgical benefits to Brian E. Hass, MD, PA, for any services furnished to me by this physician when insurance is applicable. I understand that I am financially responsible for the charges regardless of my coverage. I further agree that in the event such account must be referred to a collection agency or an attorney for court collections, I will be held responsible for any and all cost resulting from such action. A photocopy of this authorization or faxed copy shall be considered as effective and as valid as the original.

X \_\_\_\_\_ Date: \_\_\_\_\_