INSURANCE INFORMATION

MCS Therapy
609 W Cottonwood Lane Suite 1
Casa Grande, AZ 85122
520-424-1100 Fax 520-413-5787

Patient Name:	Birth Date:	Age:	Sex:	SS #:
Address:	City:	State:		Zip Code:
Phone:	Diagnoses:			
Father:	Phone:	Mother:		Phone:
Referred By:	Support Coordinator Name:			
Primary Physician Name:				Phone:
Primary Medical Insurance Company Name:	Employer:			
Policy Holder's Name:	Birth Date:			SS #:
Policy Holder's Address (If different than Patient):	City:	State:		Zip Code:
Policy ID #:	Group #:			
Send Insurance Claims to:				Phone:
Insurance Mailing Address:	City:	State:		Zip Code:
Secondary Medical Insurance Company Name:	Employer:			
Policy Holder's Name:	Birth Date:			SS #:
Policy ID #:	Group #:			
Send Insurance Claims to:				Phone:
Insurance Mailing Address:	City:	State:		Zip Code:

MEDICAL INFORMATION RELEASE

I hereby authorize the release of any information, including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or companies or other health care agencies. I also authorize the release of medical records or copies of such and request that they be transferred to MCS Therapy, P O Box 172 Maricopa, AZ 85139.

FINANCIAL POLICY

I understand and agree that I am ultimately responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due upon demand. I understand that insurance claim forms will be submitted to my insurance company as a matter of convenience. I understand and agree that if it becomes necessary to retain an attorney and/or collection agency for the collection of any outstanding charges, whether or not a lawsuit is filed on my account, I will be responsible for any attorney and/of collection fees and court costs in addition to the outstanding balance. Patients authorized for services by the Arizona Department of Economic Security, Division of Developmental Disabilities, are not responsible for payment of charges.

Assignment of Benefits

I request that payment of authorized insurance benefit be made on my behalf to MCS Therapy.

Parent/Legal Guardian Signature

Today's Date

Parent/Legal Guardian Name (printed)

Patient Name (printed)