KERN ENDOCRINE CENTER
INSURANCE INFORMATION

***PRIMARY INSURANCE NAME*:** ____

INSURANCE ID#: ________________________ **GROUP #** ______________________

INSURED NAME: ____

INSURED SS# ___________________ **INSURED DOB** _________________________

COPAY AMOUNT _______________ **PATIENT RELATION TO INSURED:**
SELF: _____ **SPOUSE:** ______ **MINOR:** ______

***SECONDARY INSURANCE NAME*:** ____

INSURANCE ID#: ________________________ **GROUP #** ______________________

INSURED NAME: ____

INSURED SS# ___________________ **INSURED DOB** _________________________

COPAY AMOUNT _______________ **PATIENT RELATION TO INSURED:**
SELF: _____ **SPOUSE:** ______ **MINOR:** ______

AUTHORIZATION:

1. While at the Kern Endocrine Center, I consent to all medical care, examinations and test determined to be necessary for me. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. If I refuse treatment that is suggested for me or do not complete any treatments protocol recommended to me, I will not hold the Kern Endocrine Center/ Jasleen Duggal, MD or any individual responsible for any of the consequences.
2. I authorize assignment of benefits due to be paid directly to the Kern Endocrine Center/Jasleen Duggal, MD. I understand I am financially responsible for the charges not covered by this authorization.
3. I authorize the Kern Endocrine Center to release any information required to my insurance company to process my claims.
4. I hereby authorize my physician to release information to my referring doctor and/or Primary Care Physician(s).
5. I understand all of the above and hereby state that the information provided is correct. I understand I am financially responsible for delays or denials of insurance claims due to incorrect information. My signature indicates that I have read the above and grant the request of authorization.

Patient Signature: ______________________________________ **Date:** ___________

Patient Name Printed: ____