THE HAND & WRIST CENTER
Specialists in diagnoses, rehabilitation and surgery

PATIENT NAME: ____ **TODAY'S DATE:** ___________________

***SECONDARY* INSURANCE TYPE AND NAME:**

☐ CASH-PAY ☐ PPO ☐ OUT OF NETWORK ☐ *WORKERS' COMP. ☐ MEDICARE ☐ HMO ☐ OTHER

INSURANCE NAME: _______________________________________ **CONTACT PERSON:** _________________________

ADDRESS: ____

CITY: _______________________________________ STATE: ______________ ZIP CODE:_________________

PHONE: (________) _______________________ FAX: (________)_________________________

NAME OF INSURED: ____ **INSURED'S DATE OF BIRTH:** ________________

YOUR RELATIONSHIP TO INSURED: (circle one) SELF SPOUSE CHILD OTHER: ________________________

INSURED'S SOCIAL SECURITY NUMBER or SUBSCRIBER I.D#: ______________________________

PLAN GROUP NO.: _________________________

DATE OF YOUR INJURY/ SYMPTOMS ONSET: _____________________________________

*WORKERS' COMP CLAIM NO.: _____________________________________

***TERTIARY (THIRD)* INSURANCE TYPE AND NAME:**

☐ CASH-PAY ☐ PPO ☐ OUT OF NETWORK ☐ *WORKERS' COMP. ☐ MEDICARE ☐ HMO ☐ OTHER

INSURANCE NAME: _______________________________________ **CONTACT PERSON:** _________________________

ADDRESS: ____

CITY: _______________________________________ STATE: ______________ ZIP CODE:_________________

PHONE: (________) _______________________ FAX: (________)_________________________

NAME OF INSURED: ____ **INSURED'S DATE OF BIRTH:** ________________

YOUR RELATIONSHIP TO INSURED: (circle one) SELF SPOUSE CHILD OTHER: ________________________

INSURED'S SOCIAL SECURITY NUMBER or SUBSCRIBER I.D#: ______________________________

PLAN GROUP NO.: _________________________

DATE OF YOUR INJURY/ SYMPTOMS ONSET: _____________________________________

*WORKERS' COMP CLAIM NO.: _____________________________________

➔ **NOTE: IF YOU HAVE MORE THAN THREE INSURANCE PLANS, PLEASE SPEAK WITH OUR STAFF.**

MULTIPLE INSURANCE PLANS DISCLAIMER: Please note that you (or the insured) are responsible for ensuring that the correct "Coordination of Benefits" is in effect at all times when multiple insurance policies are active. Coordination of Benefits relates to the order in which multiple plans pay benefits for your medical treatment. You are responsible for informing our office which plan is primary, secondary, etc. from your initial visit and throughout your entire care. **If you (the patient) fail to inform our office of the correct insurance order and/or an error is discovered relating to your Coordination of Benefits, we reserve the right to refuse to bill multiple insurance plans on your behalf.**

PATIENT SIGNATURE: ____ **DATE:** ___________________

(HWC 10-01-19)