INSURANCE INFORMATION

In order for us to file a claim on your behalf, please complete this section entirely.
If you do not have this information, we may need to reschedule your visit today.

Today's Date: _____________ Date of Birth: _________________________

Patient First Name: ____________________________ Patient Last Name: _______________________________

Person financially responsible (if different from the patient): ____

Contact information: Home#: (____) __________Work#: (____) ______________Mobile#: (____)___________

Primary Insurance Company: ______________________________ Plan Type: ☐HMO ☐PPO ☐Other

Policy #: ______________________ Group#: ___________________ Effective Date: ____________________

Name of Person Insured: ____________________________ Employer: _______________________________

Date of Birth: __________________ Social Security #: ___________________ Relation: ________________

Secondary Insurance Company: ______________________________ Plan Type:☐ HMO ☐PPO ☐Other

Policy #: ______________________ Group#: ___________________ Effective Date: ____________________

Name of Person Insured: ____________________________ Employer: _______________________________

Date of Birth: __________________ Social Security #: ___________________ Relation: ________________

My signature below authorizes InMotion Foot and Ankle Center and its management company, Ultra Medical Solutions, to bill my insurance directly for services rendered. I understand that I am ultimately responsible for paying any balance due on my account. I have given accurate and up to date information above.

_________________________________ _______________________________ _________________
Printed Name Signature Date

@UMS 10-2016