ANDREWS & ASSOCIATES, INC. INSURANCE INFORMATION AND RELEASE

In order to bill health insurance or other third-party payers for services provided to you, we need some important information. By your signature below, you acknowledge that we will provide certain Protected Health Information to the company you list below. We acknowledge that you may recind this authorization at any time, but that you will be responsible for all amounts billed to your account if not paid by another payer. This authorization will continue until all communication regarding your account is completed with your third-party payer.

PATIENT'S INFORMATION		
FIRST NAME	MI	LAST NAME
STREET ADDRESS		
CITY, STATE AND ZIP CODE		
SOCIAL SECURITY NUMBER		
TELEPHONE NUMBER		
DATE OF BIRTH	MARITAL STATUS	
GENDER	EMPLOYMENT STATUS	

INSURED'S INFORMATION		
FIRST NAME	MI	LAST NAME
STREET ADDRESS		
CITY, STATE AND ZIP CODE		
SOCIAL SECURITY NUMBER		
TELEPHONE NUMBER		
DATE OF BIRTH	MARITAL STATUS	
GENDER	EMPLOYMENT STATUS	

INFORMATION ABOUT PRIMARY INSURANCE
INSURED'S ID NUMBER
POLICY NUMBER
PLAN NAME OR PROGRAM NAME (e.g., Blue Select)
EMPLOYER OR SCHOOL NAME ON THE POLICY

INFORMATION ABOUT SECONDARY INSURANCE
INSURED'S ID NUMBER
POLICY NUMBER
PLAN NAME OR PROGRAM NAME (e.g., Blue Select)
EMPLOYER OR SCHOOL NAME ON THE POLICY

I/We authorize the release of any medical or other information necessry to process claims related to my/our treatment. I also request assignment of any benefits for my treatment to Andrews & Associates, Inc.

_____	_____	_____
PRINT NAME	SIGNATURE	DATE
_____	_____	_____
PRINT NAME	SIGNATURE	DATE
_____	_____	_____
PRINT NAME	SIGNATURE	DATE