3401 Market St, Suite 135, Philadelphia, PA 19104-3315
(phone) 215-387-0550 (fax) 215-387-0556

PATIENT'S NAME: _____ **PHONE #:** ( )_____ **DOB:** _____

AGE: _____ **SEX:** M F **RACE:**_____ **SOC.SEC#:** _____

ADDRESS: _____ **CITY/STATE/ZIP CODE:** _____

REFERRING PHYSICIAN: _____ **PRIMARY PHYSICIAN:** _____

ADDRESS: _____ **ADDRESS:** _____

CITY/STATE/ZIP CODE: _____ **CITY/STATE/ZIP CODE:** _____

PHONE #: ( )_____ **PHONE #:** ( )_____

PRIME INS. NAME: _____ **2ND INS NAME:**_____

PRIME INS. ADDRESS: _____ **2ND INS. ADDRESS** _____

PRIME INS. ID #:_____ **2ND INS. ID #:**_____

PRIME INS. GROUP #: _____ **2ND INS.GROUP#:** _____

PRIME INS. PHONE:_____ **2ND INS. PHONE:**_____

EFFECTIVE DATE: _____ **EFFECTIVE DATE:** _____

EXPIRATION DATE: _____ **EXPIRATION DATE:** _____

MAJOR MEDICAL COVERAGE? _____

SUBSCRIBER'S NAME (if different): _____

SUBSCRIBER'S D.O.B: _____ **SUBSCRIBER'S SEX:** M F

RELATIONSHIP TO SUBSCRIBER: _____

SUBSCRIBER'S ADDRESS: _____

SPECIALIST'S CO-PAY: ____$_____

WAS THE ILLNESS/INJURY DUE TO AN ACCIDENT? **YES** **NO**

DATE OF INJURY/ACCIDENT:_____

NAME OF AUTO INSURANCE:_____

AUTO INSURANCE CO. ADDRESS: _____

CITY/STATE/ZIP CODE: _____

AUTO INSURANCE PHONE NO: _____

NAME OF POLICY HOLDER: _____

RELATIONSHIP TO POLICY HOLDER_____

AUTO INSURANCE CLAIM NO.: _____

AUTO INSURANCE POLICY NO.: _____

AUTO INSURANCE CONTACT PERSON/ADJUSTER NAME: _____

IS THIS A WORKMAN'S COMPENSATION CASE? YES NO

CASE NO: _____ **TYPE:** _____**CLASS:** _____

STATUS: ACTIVE INACTIVE

FIRST SERVICED: _____

NAME OF WORKMAN'S COMP. INSURANCE:_____

ADDRESS: _____

CITY/STATE/ZIP CODE: _____

INSURANCE PHONE NO: _____

EMPLOYER/SUBSCRIBER: _____

CLAIM NO.: _____

POLICY NO.: _____

INSURANCE CO. CONTACT PERSON/ADJUSTER NAME: _____

ATTORNEY'S NAME: _____

ATTORNEY'S ADDRESS: _____

CITY/STATE/ZIP CODE: _____

ATTORNEY'S PHONE NUMBER: _____

ASSIGNMENT OF BENEFITS:

I hereby assign to Jennifer Chu M.D., LLC any insurance or other third-party benefits available for health-care services provided to me. I also understand that if benefits are assigned, or if by contractual arrangement, payment to the practice will be made by my insurance, and I am responsible for co-payments and deductibles and that these amounts are due at the time services are rendered. I understand that the above practice has the right to refuse or accept assignment of such benefits (except when prohibited by contract). I also understand that in the event that services rendered are not covered under my "insurance", I will accept financial responsibility for all services provided to me. If benefits are not assigned to this practice, I agree to forward to the practice, all "insurance" payments that I receive for services rendered to me immediately upon receipt and/or to make payment, in full for the services rendered to me (depending upon the agreement) at this time.

Signature of patient/Legal Guardian_____Date:_____

FOR RELEASE OF INFORMATION:
I authorize the release of any medical or other information as is necessary to process this claim based upon the "HIPPA Notice of Privacy Practices" information provided to me under separate cover. This information is on file as the permanent record and may be amended as is necessary.

Signature of patient/Legal Guardian_____ Date:_____