INSURANCE BENEFITS CONSENT FORM

Patient Information		
First Name	**Last Name**	**Date of Birth**

Insurance Information		
Company Name	**Group Number**	**Policy Holder Name**

I, the undersigned patient, hereby acknowledge and consent to utilize my insurance benefits for medical services provided in accordance with the terms and conditions of my insurance policy.

I understand and agree to the following:

I am aware that my insurance policy with [Insurance Company Name] provides coverage for specific medical services or treatments as outlined in the policy documents.

I understand that I am responsible for any co-payments, deductibles, or any other out-of-pocket expenses as required by my insurance policy. Any services not covered by insurance will be my responsibility to pay.

I acknowledge that using in-network healthcare providers may result in reduced costs for covered services. I understand the importance of verifying the network status of providers and facilities with my insurance company.

I understand that some services or treatments may require pre-authorization from my insurance company before they are provided. I agree to comply with obtaining any necessary authorizations.

I am aware that certain services or treatments may not be covered under my insurance policy. I have reviewed my policy documents or will seek clarification from my insurance company regarding any exclusions or limitations.

I acknowledge that any costs not covered by insurance will be my responsibility to pay directly to the Provider.

Signature: /sn1/ Signature Date: /ds1/