The Enrichment Garden
1911 N 11th Street
P O Box 2536
Bismarck ND 58502
Phone (701) 258-1569 Fax (701) 223-1669

PATIENT INSURANCE INFORMATION

Patient Name: ____

Parent/Guardian Name: _______________________________________

E-mail Address: ____

Address: ____

Phone: _______________________ DOB: _______________________

Referring Physician: ____

Physician Address & Phone: ____________________________________

____________________ Primary Insurance	____________________ Secondary Insurance
____________________ Policy Holder Name	____________________ Policy Holder Name
____________________ Policy #	____________________ Policy #
____________________ Address	____________________ Address
____________________ City State Zip	____________________ City State Zip

(Please note: Medicaid is ALWAYS secondary to a commercial insurance policy)

I understand that I am financially responsible for all charges incurred, including the balance remaining after payment of insurance benefits. I understand that I am responsible for payment of insurance deductibles, coinsurance and/or co-payments directly to The Enrichment Garden.

I understand that it is my responsibility to provide current and correct insurance information to The Enrichment Garden. If incorrect information is on file due to my lack of providing this information, I may be held responsible for any charges that my insurance company denies.

I authorize my insurance benefits to be paid directly to The Enrichment Garden

I authorize photocopies of this form to be valid as the original.

I authorize the release of any medical information necessary to process claims related to services provided by The Enrichment Garden.

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Signature of Responsible Party Date

PLEASE ATTACH COPY OF INSURANCE CARD(S)