



Stephen R. Klapper, M.D., F.A.C.S.

INSURANCE INFORMATION

\*\*A legible photocopy (front & back) of your insurance and/or Medicare card(s) is necessary to appropriately file insurance claim(s) on your behalf. The following information must be carefully completed in its entirety or your insurance claim may not be accepted by your carrier. A copy of the patient's and/or guarantor's driver's license is also required prior to your visit. Insurance co-payments are required at time of visit. Office financial policies are available upon request.

Primary insurance: \_\_\_\_\_ effective date: \_\_\_/\_\_\_/\_\_\_

Policy I.D.# \_\_\_\_\_ Group # \_\_\_\_\_

Still employed: \_\_\_yes \_\_\_no Guarantor still employed: \_\_\_yes \_\_\_no

Guarantor Name: \_\_\_\_\_ Guarantor date of birth: \_\_\_/\_\_\_/\_\_\_

Guarantor S.S.#: \_\_\_\_\_ Guarantor Employer: \_\_\_\_\_

Patient's relationship to Guarantor: self spouse child other: \_\_\_\_\_  
(Circle one)

Secondary insurance: \_\_\_\_\_ effective date: \_\_\_/\_\_\_/\_\_\_

Name/relationship of insured: \_\_\_\_\_

Still employed: \_\_\_yes \_\_\_no Guarantor still employed: \_\_\_yes \_\_\_no

Policy I.D.# \_\_\_\_\_ Group # \_\_\_\_\_

Guarantor Name: \_\_\_\_\_ Guarantor date of birth: \_\_\_/\_\_\_/\_\_\_

Guarantor S.S.#: \_\_\_\_\_ Guarantor Employer: \_\_\_\_\_

Patient's relationship to Guarantor: self spouse child other: \_\_\_\_\_  
(Circle one)

Tertiary insurance: \_\_\_\_\_ effective date: \_\_\_/\_\_\_/\_\_\_

Name/relationship of insured: \_\_\_\_\_

Still employed: \_\_\_yes \_\_\_no Guarantor still employed: \_\_\_yes \_\_\_no

Policy I.D.# \_\_\_\_\_ Group # \_\_\_\_\_

By signing below, I authorize this office and any holder of information about me to release to my health care plan, Centers for Medicare and Medicaid Services (CMS) and/or its (their) agents all medical information acquired in the course of my examination(s) and/or treatment(s). I accept full financial responsibility for all charges not covered by my health care plan and/or Medicare (CMS). I authorize my insurance carrier(s) and/or Medicare (CMS) to pay authorized benefits directly to Stephen R. Klapper, M.D., L.L.C.

PATIENT/GUARANTOR SIGNATURE:

X \_\_\_\_\_ DATE: \_\_\_/\_\_\_/200\_\_