

LIVING BETTER INSTITUTE, INC.
529 State Route 515, Suite 203A Vernon, NJ 07462
www.sussextherapy.com

Patient Information:

First Name: _____ Last Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell: _____
Sex: _____ Birthdate: _____ Marital Status: _____

Responsible Party Information: (if different from above)

First Name: _____ Last Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell: _____
Sex: _____ Birthdate: _____ Marital Status: _____

Insurance Information:

Primary Insurance Company: _____
Subscriber Name: _____
ID Number: _____ Address: _____
City: _____ State: _____ Zip: _____ Group Number: _____
Relationship to Insured: _____

Secondary Insurance Company: _____
Address: _____ City: _____ State: _____ Zip: _____
Subscriber Name: _____
ID Number: _____ Group Number: _____
Relationship to Insured: _____

***** YOU are responsible for providing correct and complete insurance information *****

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or depends. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependants, and that I will be bound by this signature as though the undersigned had personally signed the particular claim:

I _____, hereby authorize _____ to pay
(Name of Insured) (Name of Insurance Company)
and hereby assign directly to **Charles Markham LLC** all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Charles Markham LLC will be credited to my account, in accordance with the above said assignment.

(Authorized Signature of Subscriber)

(Date)

***** Please make a copy (front and back) of all insurance cards and attach to this document *****