Dr. Fred E. Russo C.C.S.P.
Tallahassee Chiropractic Sports Medicine & Rehab Center
230 John Knox Rd #3 Tallahassee, FL 32303 Phone (850) 422-2225 Fax (850) 422-2509

INSURANCE INFORMATION

Patient Last Name_____**First Name**_____**Middle**_____

Insurance Type: Check all those that apply: ☐ Group Health Insurance ☐ Medicare

Insurance Information
Insurance Company_____ Phone # ( )_____

Address:_____

Insured's Name_____ Date of Birth_____

ID/Policy #_____ Group #_____

Secondary Insurance
Insurance Company_____ Phone# ( )_____

Address:_____

Insured's Name_____ Date of Birth_____

ID/Policy #_____ Group #_____

Responsible Party Complete this section if you are not the patient but are responsible for the bill

Responsible Party_____

Relationship to Patient_____ SS#_____ DOB_____

Home Address:_____ Apt #_____

City_____ State_____ Zip_____

Home Phone#_____ Work_____ Cell_____

Employer Name_____ Occupation_____

Assignment of Benefits

I authorize the **release** of any medical or other information necessary to process my claims. I assign insurance benefits for services rendered to me by Dr. Fred E. Russo and any payments be made directly to 230 John Knox Rd #3 Tallahassee, FL 32303. This is a permanent authorization that I may revoke at any time by written notice.

X_____ _____
Signature of patient or person acting on patients behalf Date

GI/MM