

**INSURANCE INFORMATION**

Do you have insurance coverage? \_\_\_\_\_

Name of insurance company \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ Date of Birth \_\_\_\_\_

Member ID# \_\_\_\_\_ Group# \_\_\_\_\_

Address for claims \_\_\_\_\_

Phone # \_\_\_\_\_

(Please have your insurance card and photo identification ready to present to front office)

**AUTHORIZATION AND ASSIGNMENT OF BENEFITS (Please sign both)**

I authorize Michael A. Tolson to furnish information to insurance carriers only concerning my treatments.

Date \_\_\_\_\_ Signature \_\_\_\_\_

I assign Michael A. Tolson all payments for medical services rendered to me or my dependent. I understand that I am responsible for any amount not covered by assigned insurance.

Date \_\_\_\_\_ Signature \_\_\_\_\_

**PHOTOGRAPHY CONSENT**

I hereby give my permission to Michael A. Tolson to take photographs for diagnostic purposes, to enhance the medical report, during surgery, and postoperatively for evaluation purposes. I agree that these photographs will remain his property.

Date \_\_\_\_\_ Signature \_\_\_\_\_

I further authorize him to use such photography for teaching purposes or to illustrate scientific papers, books, or lectures.

Date \_\_\_\_\_ Signature \_\_\_\_\_