SP ASSOCIATES

Patient Name:

Primary Insurance **None:** ☐

Insurance Name:_____ID:_____

Group No:_____Group Name/Employer:_____

Insured Name:_____

Insured Address:_____City/State/Zip:_____

Insured Relationship to Patient:_____DOB:_____SSN:_____

Secondary Insurance

Insurance Name:_____ID:_____

Group No:_____Group Name/Employer:_____

Insured Name:_____

Insured Address:_____City/State/Zip:_____

Insured Relationship to Patient:_____DOB:_____SSN:_____

Statesboro Psychiatric Associates (SPA) does not participate with Medicare, Tricare or Medicaid. I understand that if covered by any of these entities that I must sign a waiver in order to receive treatment at SPA. I understand that the waiver states that I may not file claims on my behalf to Medicare, Tricare or Medicaid for services rendered by SPA, and that I am fully responsible for payment of these services. I also understand that neither I nor SPA will file with insurance that is secondary to Medicare, and that by signing the waiver I am fully responsible for office visits.

Signature of Patient/Responsible Party:_____**Date:**_____
*Digital Signature

I understand that it is my responsibility to alert Statesboro Psychiatric Associates to any and all changes in my insurance coverage, and that failure to provide these updates in a timely fashion may result in denial of claims by my new insurance company, and that I will be fully responsible for payment of these services.

Signature of Patient/Responsible Party:_____**Date:**_____
*Digital Signature