



Patient Benefit Information

Professional services rendered to you (or a minor for whom you are responsible) by Heelex/JSPHyMgmt LLC are your sole financial responsibility. You further understand that Heelex/JSPHyMgmt LLC will bill your insurance as a courtesy, but you are ultimately responsible for payment. You are financially responsible for any and all allowable balances not paid by your insurance (i.e. deductible, copay, coinsurance, and denied charges). You are expected to pay your estimated personal portion the day of your visit. Any unpaid balance will be reflected in your monthly billing statement. Any unpaid charges on an account for 90 days are subject to collection action.

Patient Name: _____ Date of Birth: _____

Subscriber Name: _____ Date of Birth: _____

Primary Insurance: _____ Phone Number: _____

Member ID: _____ Group #: _____

Verified Benefits By: _____ Reference #: _____

Effective Date: _____ Ind / Fam Deductible: _____

Coinsurance / Copay : _____ Ind / Fam Out of Pocket: _____

Authorization Required: NO YES _____

Comments: _____

Estimated Total Cost of treatment (Consult, Sim day, and all Tx days) :

Secondary Insurance: _____ Phone Number: _____

Dependent Name: _____ Date of Birth: _____

Member ID: _____ Group #: _____

Verified Benefits By: _____ Reference #: _____

Effective Date: _____ Ind / Fam Deductible: _____

Coinsurance / Copay : _____ Ind / Fam Out of Pocket: _____

Authorization Required: NO YES _____

Comments: _____

Patient Signature: _____ Date: _____