



PULMONARY CLINIC OF THE CAROLINAS, PC

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Lincolnton, NC 28092
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Gastonia, NC 28054
704.867.8742 • Fax 704.867.8891

ACCOUNT NUMBER _____

INSURANCE VERIFICATION FORM

PATIENT _____ ADDRESS _____

DOB _____

NAME OF INSURANCE CO. _____ PH# (H) _____ (W) _____

POLICY HOLDER _____ EMPLOYER _____

ADDRESS _____

RELATIONSHIP TO PATIENT _____

I.D.# _____

SS# _____ DOB _____

GROUP # _____

DEDUCTIBLE \$ _____

CO-PAY \$ _____

HAS DEDUCTIBLE BEEN MET? _____ YES _____ NO

EFFECTIVE DATE _____

MAIL CLAIMS TO: _____

I HAVE READ AND UNDERSTAND THAT BY SIGNING THIS AGREEMENT IN CONSIDERATION OF SERVICES RENDERED TO ABOVE NAMED PATIENT BY PULMONARY CLINIC OF THE CAROLINAS, PC, I AM JOINTLY AND SEVERELY LIABLE FOR PAYMENT OF THE PATIENT'S ACCOUNT BALANCE. THIS AGREEMENT IS AN ABSOLUTE, CONTINUING, AND UNLIMITED GUARANTEE OF PAYMENT AND WILL APPLY TO ALL CHARGES INCURRED BY THE ABOVE NAMED PATIENT DURING THE TREATMENT AND FUTURE CARE RENDERED BY PULMONARY CLINIC OF THE CAROLINAS, PC. THE RESPONSIBLE PARTY IS LIABLE FOR ALL PAYMENTS, BUT PULMONARY CLINIC AGREES TO PROVIDE NECESSARY INSURANCE CLAIM FORMS FOR INSURANCE REIMBURSEMENT.

RESPONSIBLE PARTY SIGNATURE _____

DATE _____ / _____ / _____