



The Hull Institute, LLC
lifestyle management

INSURANCE INFORMATION

Client Name: _____ Birth Date: _____

Client Address: _____

City: _____ State: _____ ZIP: _____

Client Phone Number: () _____ SSN: _____

Subscriber Name: _____ Birth Date: _____

Subscriber Address: _____

City: _____ State: _____ ZIP: _____

Subscriber Phone Number: () _____

Subscriber Phone Number: () _____ SSN #: _____

Relationship to Client: SELF SPOUSE PARENT OTHER

Name of Insurance Company: _____

Effective Date: _____

Insurance Company Address: _____

Subscriber ID: _____ Group #: _____

Subscriber Employer: _____

Employer Address: _____

City: _____ State: _____ ZIP: _____

DOES YOUR INSURANCE COMPANY REQUIRE AN AUTHORIZATION? YES NO

DID YOU CALL FOR AN AUTHORIZATION PRIOR TO TODAY'S APPT? YES NO

AUTHORIZATIONS

I verify that this information is correct. I authorize The Hull Institute, LLC to file claims to my insurance company. I authorize The Hull Institute, LLC to release any medical information necessary to process my claims. I understand that I will be financially responsible for payment of services at the time the service is rendered. I will give the office 24-hrs notice before canceling appointments or I may be charged. If an authorization is needed, and I fail to secure one prior to services being rendered, I will be financially responsible.

_____ Date: _____

Client (Parent/Guardian) Signature