A Garden for Wellness
Deana Brooksher, DC
(706) 754 – 8899

Insurance Consent Form

Patient's Full Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Date of Birth: _____
Phone Number: _____
Email: _____
Marital Status: Married/Divorced/Single/Widow
If patient is under age 18, who is the Responsible Party? _____

Primary Insurance Information:

Name of Insurance Company: _____
ID Number: _____
Group Number: _____

Member's Name: _____
Date of Birth: _____
Relationship to the Patient: _____

Employer: _____

Secondary Insurance Information:

Name of Insurance Company: _____
ID Number: _____
Group Number: _____

I authorize the release of any medical or other information to process all claims performed. I also request payment of benefits be made directly to A Garden for Wellness. We are filing insurance as a courtesy to you, therefore if your insurance company fails to pay for any treatment on your behalf, you will be responsible for the balance due. By signing below, I am agreeing to the above-mentioned terms and conditions.

Signature of patient or responsible party: _____
Date: _____