Sandra Norris Wheeler
LMT, Lic #1610

INSURANCE INFORMATION

EMAIL: _____

NAME: _____ DATE:_____

MAILING ADDRESS: _____

TELEPHONE: (____)_____ home (____)_____work (____)_____ cell

DOB: _____/____/_____ SSN: _____ ❑ male ❑ female

NAME OF INSURANCE COMPANY: _____

ADDRESS: _____

PHONE: (____)_____ CLAIMS ADJUSTER (if known): _____

NAMED INSURED: _____ SSN: _____

RELATIONSHIP: _____ GROUP #: _____ ID#: _____

CLAIM NUMBER: _____ DATE OF INJURY: _____/____/_____

REFERRING PHYSICIAN: _____

ADDRESS: _____

PHONE: (____)_____ THIS CONDITION IS A RESULT OF: _____

_____

Please fill in and print the above information as completely as possible.

Your insurance company will be billed for you. You will be responsible for all unpaid services, your co-payment and deductible.

I have read and understand this agreement.

Signature: _____ Date: _____

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