George Ankuta, Ph.D.

16233 Sylvester Rd SW Suite G-80
Burien, WA 98166
(206) 241-9068 * Fax (206) 241-2651

INSURANCE INFORMATION

Subscriber / Guarantor Name: _____

Address:_____City:_____Zip Code_____

Phone:_____Social Security Number: _____

Driver's License Number: _____ Date of Birth: _____
Occupation: _____ Employer: _____
City/County: _____ Work Phone: _____

Primary Insurance Company: _____
Member Number: _____Group Number: _____
Secondary Insurance Company: _____
Member Number: _____ Group Number: _____

If applicable, Labor & Industries Claim Number: _____
Date of Injury: _____

Name of Referring Physician: _____

I hereby authorize my insurance benefits be paid directly to George Ankuta, Ph.D. and I am financially responsible for non-covered services. I also authorize Dr. Ankuta to release any information required to process this claim or to obtain authorization for services. I understand that my records may contain information regarding drug/alcohol abuse, sexually transmitted diseases, treatment of HIV (AIDS virus), mental illness, and/or psychiatric treatment. I give my specific authorization for these records to be released to any person or corporation which is or may be liable under a contract with Dr. Ankuta or the patient. This consent, with respect to the conditions noted above, shall be effective only so long as reasonably necessary to obtain reimbursement.

Date: _____ Signature: _____

Relationship to Patient: _____

Witness: _____