TREE OF LIFE
INTEGRATIVE FAMILY MEDICINE
Restore & Renew for a Healthier You

Website: www.tolifm.com
Phone: 609-354-5553
Fax: (833)-989-2484
Address: 24285 Katy Freeway Suite 300, Katy, TX, 77494

New Patient Billing Form

CIRCLE ONE IF APPLIES: MVA | WC
Date of Service: _____

Patient's Name:_____Male: Female: DOB:___/___/_____
Patient's SS#: __ __ __/__ __/__ __ __ __ Home Phone:__ __ __- __ __ __-__ __ __ __
Address: _____ Apartment number:_____
City, State and Zip Code: _____, _____ ,_____
Insurance: Provided Copy of InsuranceCard/s? Yes _____ NO_____

(IF A COPY OF THE INSURANCE CARD IS ATTACHED NO NEED TO WRITE THE ADDRESS)

- **Primary Insurance Name:**_____

Policy Number:_____ Subscriber DOB: ____/_____/_____
Subscriber's Name:_____Male: Female:
Subscriber's Relation to Patient: M F H W Other:_____
Address:_____
City, State and Zip Code: _____, _____ ,_____

- **Secondary Insurance Name:**_____

Policy Number: _____ Subscriber's DOB:_____/_____/_____
Subscriber's Name:_____
Subscriber's Relation to Patient: M F H W Other:_____
Address:_____
City, State and Zip Code: _____, _____ ,_____

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMA TION

I authorize the release of any medical and/or employment information necessary to the above-named insurance company, and/or attorney to process any claims and request that payment of medical benefits be assigned to Dr. _____ understand that I am responsible for payment of medical services rendered. If any checks are sent directly to me by my insurance carrier, I will forward the check to Dr._____

_____ _____
Parent, Guardian, or Authorized Signature Date