Client Name:	Email Address:	Phone:

Secondary Insurance:

Secondary Insurance Company:	Insurance Co. Address:	Insurance Co. City/State/Zip :
Insurance Co. Phone #:	**Policy Holder's I.D #:**	**Plan Name:**
Effective Date:	**Policy/FECA #:**	**Group #:**
Policy Holder's Employer:	**Co-Pay Amount:**	**Client's Relationship to Policy Holder:**
Policy Holder's Name:	**Policy Holder's Address:**	**Policy Holder's City/State/Zip:**
Policy Holder's Birth Date:	**Policy Holder's Phone #:**	**Preauthorization Required?:**

I authorize Southern Maryland Associates to file insurance claims, and accept payments on my behalf, for visits to this office. I understand I am responsible for any balance not covered by my insurance.

Signed: X_____ Date:_____