Glenn E. Cahn, PhD PLLC
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Wilmington, NC 28403
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Insurance & Financial Responsibility

Client name: _____

Primary insurance plan's name:_____

Secondary insurance plan's name, if any, and policy #:_____

_____

If insurance is under someone's name who lives at a different address than the client:

Subscriber name:_____ **Phone**:_____

Subscriber address:_____

Subscriber City/State/Zip:_____

My insurance company has told Dr. Glenn Cahn that the following amounts apply to services, but they do not automatically guarantee payment for any service that he may provide to me.

Co-pay: $_____ Deductible: $_____ % Coverage:_____

No coverage[ ] Agreed upon cost: $_____

I hereby give Dr. Glenn Cahn permission to bill my insurance company for services he has provided me or to _____. I also authorize Dr. Cahn to release all necessary information that the insurance company may require to enable him to obtain full payment for his services. I also authorize the use of my signature on all health claim forms for myself or my dependent who has received services from Dr. Cahn.

I also agree to pay Dr. Cahn all amounts owed for service provided by him should my insurance company not fully reimburse him for his services. Such amounts include but are not limited to co-pays, deductibles, co-insurance (the percentage not covered as shown above), or services not covered for any reason. If such payment is more than 30 days late and necessitates use of a collection agency, an additional $25. fee will be added to cover such cost.

_____ _____
Signature (Parent or guardian for a minor) Date