VERMA SPINE

Kushagra Verma, M.D., M.S., FAAOS

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IF PATIENT IS A MINOR OR A STUDENT:

School Name: _____

Address: _____

Phone: _____

Father's Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Phone: _____

Mother's Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Phone: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I also authorize VS· or insurance company to release any information required to process my claims, determine the benefits payable for related equipment or services to the organization. the Health Care financing administration. A copy of this authorization will be sent to the Health care financing administration, my insurance company or other entity If requested. I, the above listed, authorize and direct the above listed insurance company to pay by check, made out and mailed to VS , 3851 Katella Avenue, Suite 255, Los Alamitos, CA 90278. If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct the above mentioned insurance company to make the check to me and man it as follows to: VS , 3851 Katella Avenue, Suite 255, Los Alamitos, CA 90278.

If the patient is less than 18 years of age, guarantor must sign.

Signature of Financially Responsible Party: _____

Relationship to Patient: _____

Date: _____

* VS = Verma Spine