Mind Opener
Billing/Insurance/Payment Services

Jodi Cambra
(949) 400-6474 / Fax (949) 215-5600

***This form authorizes Jodi Cambra to contact me or leave a message regarding the status of my account

PATIENT NAME: ___________________________ D.O.B. :__________________________

I may need to communicate with you regarding your billing, insurance, or payment issue. Please indicate how you wish to be contacted:

Cell phone: ___________________________ Okay to leave a message? ________
Work phone: ___________________________ Okay to leave a message? ________
Home phone: ___________________________ Okay to leave a message? ________
E-mail: ______________________________

Since I am a billing and insurance service and am located in a different location from the doctor shown above, some or all of your "personal and insurance claim information" may need to be faxed or mailed to your insurance carrier. Your signature below indicates your authorization so that we may obtain payment or information regarding your account.

My signature below indicates that I understand and agree to all of the above. I also understand that this "consent" will remain in effect while I am under Dr. Shulman's care. I also understand that if ANY of the above information changes, or there is a charge to my insurance coverage or information, that I will notify Dr. Shulman and this billing service promptly.

____ ____________________
Print name of patient Date

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Signature of patient/Responsible Party