JAMES D WETHE, MD – American Board of Plastic Surgery
3440 Lomita Boulevard, Suite 220 Torrance CA 90505

INSURANCE INFORMATION

Patient Name:_____ DOB _____

Insured Name:_____ DOB _____

Relationship to Insured: _____

Primary Insurance: _____Phone #_____

Address: _____

Policy ID #_____Group #_____Effective Date_____

Employer Name _____ Phone # _____

Assignment of Benefits

I hereby authorize assignment and payment directly to James D. Wethe, M.D.

I HEREBY AGREE TO PAY ANY AND ALL CHARGES THAT EXCEED OR THAT ARE NOT COVERED BY INSURANCE.

_____

Signature Date Relationship to patient