Bastian Voice Institute

for voice, swallowing & airway disorders

Date: ____

Patient Name: ____

Dear____:

Please send us a copy of <u>both sides</u> of your insurance card(s) or call our office with the following information at your earliest convenience.

Insurance Company Name: ____________________________________

Billing Address: ____________________________________

____

Telephone: ____________________________________

Group or Plan Number: ____________________________________

Employee I.D. Number: ____________________________________

Office Visit Co-Pay: ____________________________________

Please note that your account will be billed to you until we receive the above information, at which point bills for services rendered will be submitted to your insurance carrier.

If you should have any questions please do not hesitate to contact our office.

Sincerely,