PRIVATE INSURANCE BILLING
THROUGH ADVANTAGE MEDICAL BILLING

LELAND MCHATTON, MFT
1430 EAST AVE #4C
Chico, CA 95926
Office Phone: (530) 566-1212
Billing Phone (530) 345-7699 Billing Fax (530)345-7677

Patient Name:_____ DOB:_____
SS#:_____Gender:_____
Address:_____ City:_____ State:_____ Zip:_____
Home Phone:_____ Alternate Phone:_____
Martial Status:_____Employer:_____
Primary Care Physician:_____ Phone:_____

Primary Insurance Company: Name:_____
Phone:_____ Subscriber Name:_____
DOB:_____ ID#:_____ Group#:_____
Address of Subscriber (if different than above):_____
City:_____ State:_____ Zip:_____
Relationship to Patient:_____

Secondary Insurance Company: Name:_____
Phone:_____ Subscriber Name:_____
DOB:_____ ID#:_____ Group#:_____
Address of Subscriber (if different than above):_____
City:_____ State:_____ Zip:_____
Relationship to Patient:_____

I, _____, (patient or above mentioned responsible party) hereby authorize Advantage Medical Billing to bill my insurance company on my behalf and to transmit any and all information necessary in order to process my claims, including past, present, and future dates of service with Leland McHatton, MFT. I understand that all such transmissions will follow HIPAA mandated confidentiality guidelines. I also agree to pay Leland McHatton, MFT in full at the time of my visits and that any insurance reimbursements will be made directly to me.

I also agree to pay Advantage Medical Billing the sum of $8.00 per date of service per patient that is billed out on my, or my family's, behalf. I understand that a holding fee of $20.00 may be collected from me at the time I first seek the services of Advantage Medical Billing for their billing services to create an account for me. Fees will be deducted from this account as accrued and other payments will be sought to cover additional billing services. Payment is expected from Advantage Medical Billing at the time services are provided.

_____ _____
Signature of patient or responsible party Date

We need your: 1) PRIMARY INS. CARD, front and back of card
2) SECONDARY INS. CARD, front and back of card (if applicable)
3) ABOVE INFORMATION COMPLETED AND AGREEMENT SIGNED

ALSO: Please provide us with any and all additional family member information for patients seeing Leland McHatton.
Name:_____ DOB:_____
Name:_____ DOB:_____
Name:_____ DOB:_____
Name:_____ DOB:_____