

NORTH STATE MEDICAL GROUP, P.A.

Patient: _____

Guarantor: _____

Account Number: _____

I have reviewed the billing information on the above account and here by certify that this is the correct information for processing my insurance.

If this information is not correct I understand that I will be responsible for any balance due if the claim is denied. I will be responsible if I do not produce the correct information in a timely fashion needed to process my claim for payment.

Patient/Guarantor Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Date: _____ Date: _____

Date: _____ Date: _____

Date: _____ Date: _____