



CLIENT SERVICE TICKET

Date:

NAME OF PATIENT:		BIRTH DATE	EMPLOYER GROUP:
STREET ADDRESS:		CITY, STATE & ZIP:	
HOME PHONE:		WORK PHONE:	
NAME OF INSURED:		BIRTH DATE	SUBSCRIBER ID # OF INSURED:
INSURANCE COMPANY & GROUP NUMBER:		CONTACT NAME & PHONE #:	
PROVIDER NAME & PHONE #:		DATE(S) OF SERVICE & BILLED AMOUNT:	

NATURE OF ISSUE:

In order to comply with current HIPAA laws regarding privacy of personal health information, I hereby authorize my insurance carrier, IPA medical group, hospital, laboratory, physician or dental office to release information regarding my personal medical, dental and any account information necessary to assist in processing claims or reconciling the account to the following agent: this includes medical, mental health and dental service:

Maniaci Insurance Services, Inc.
 500 Silver Spur Road, Suite 121
 Palos Verdes, CA 90275
 (310) 541-4824 Fax (310) 377-2016
 advocacy@maniaciinsurance.com
 Lic # 0600161

 Subscriber Signature

 Date

 Covered dependent over age 18

 Date