chiropractic

remove obstacles • restore function • improve performance • maximize potential

Account Information

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you.
We want your visit with us to be comfortable, helpful, and educational.

confidential health information

clinic id	date

1 PATIENT INFORMATION

last name	first name	m.i.

age	date of birth	social security #	sex ☐ male ☐ female

Are you here because you were involved in a vehicle collision? ☐ yes ☐ no

Are you here because you were injured at your place of employment? ☐ yes ☐ no

Are you here because you were involved in another type of accident? ☐ yes ☐ no

Who is responsible for this account?

Will you be using health insurance to supplement payment to our office*? ☐ yes ☐ no

* If YES, please complete the INSURANCE COVERAGE and INSURED INFORMATION sections of this form.

2 INSURANCE COVERAGE

type of insurance

☐ employee group health plan ☐ personal health insurance ☐ health savings account ☐ Medicare ☐ Medicaid

☐ personal injury ☐ Workers' Compensation ☐ TRICARE/CHAMPUS ☐ CHAMPVA ☐ FECA

primary insurance company	primary ins ID#	primary ins group#
secondary insurance company	secondary ins ID#	secondary ins group#

3 INSURED INFORMATION

Are the insured and patient the same person? ☐ yes ☐ no If YES, do not complete section 3.

last name	first name	m.i.

street

city	state	zip

age	date of birth	social security #	sex ☐ male ☐ female

relationship to insured ☐ spouse ☐ dependent ☐ Other ____________

We are here to service our patients the best way we know how. We understand the value of health insurance. However, because health insurance plans are intended only to supplement out of pocket expenses for care, it may not cover all the care you need. We will verify your applicable insurance benefits and report the supplemental coverage to you.

Our relationship is with each patient individually, not the insurance companies. If we believe that we may be able to help you and we accept your case, our recommendations will be based on what we believe is best for you - supported by our experience. We take great care in making our services affordable regardless of health insurance coverage.

I understand and agree to the following:

- There is no guarantee that my health insurance plan or policy will pay for all or part of my care
- I will be informed of fees and charges before the associated procedure or service is performed
- As the patient or guardian of a patient, I am ultimately responsible for all charges incurred from services rendered

____
patient or guardian signature

____
date

1 BENEFITS ASSIGNMENT

I authorize that payment of charges be made directly to the doctor(s) of this clinic. This authorization includes:

1. All insurance reimbursement for services rendered, including those which may be payable to me under my insurance plan or policy
2. Amounts owed on my behalf from proceeds of any settlement related to my case.

patient or guardian signature ____________________ date ____________________

2 INFORMATION RELEASE

I authorize the release of any necessary information to my insurance companies, pre-paid health plan or account, or government managed health plan to request payment benefits to me or my assignee.

patient or guardian signature ____________________ date ____________________

INSURANCE VERIFICATION

OFFICE USE ONLY – Please Do Not Write In This Box

Is this a **Workers' Comp** case? ☐ yes ☐ no

- Has the injury been reported? ☐ yes ☐ no
  - Name:
  - Title:
  - Is patient currently employed at place of injury? ☐ yes ☐ no
  - Name of person authorizing care:

Is this an **Auto Collision** or **Personal Injury** case? ☐ yes ☐ no

- Has it been reported to the insurance company? ☐ yes ☐ no
- Has an application for benefits been filed? ☐ yes ☐ no
- Did the police write a report? ☐ yes ☐ no
- Is auto or PI insurance primary? ☐ yes ☐ no
- Agent name and contact info:

Does the plan cover the following services?

- chiropractic adjustments ☐ yes ☐ no
- modalities:
  - hot/cold packs ☐ yes ☐ no
  - mechanical traction ☐ yes ☐ no
  - electric stimulation ☐ yes ☐ no
  - ultrasound ☐ yes ☐ no
- therapeutic exercise and activities ☐ yes ☐ no
- neuromuscular re-education ☐ yes ☐ no
- massage ☐ yes ☐ no
- manual therapy technique ☐ yes ☐ no
- exams ☐ yes ☐ no
- supports, braces, collars ☐ yes ☐ no
- pillows ☐ yes ☐ no
- nutritional supplements ☐ yes ☐ no
- orthotics ☐ yes ☐ no
- other:____________________ ☐ yes ☐ no
- other:____________________ ☐ yes ☐ no

Does the plan have a deductible? ☐ yes ☐ no

- Amount for an individual:
- Amount for the family:
- Amount currently met:
- When does the deductible renew?
- Do charges for diagnostic tests apply to the deductible?

What is the co-pay after the deductible is met?

What is the maximum yearly benefit?

What is the yearly visit cap?

Does the company assign benefits to the doctor? ☐ yes ☐ no

Are any special forms required to file claims? ☐ yes ☐ no

What is the name of the person that you spoke with?

- Last:
- First:
- ID# Extension:

Notes:

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