

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	<input type="checkbox"/> yes	<input type="checkbox"/> no
modalities:		
hot/cold packs	<input type="checkbox"/> yes	<input type="checkbox"/> no
mechanical traction	<input type="checkbox"/> yes	<input type="checkbox"/> no
electric stimulation	<input type="checkbox"/> yes	<input type="checkbox"/> no
ultrasound	<input type="checkbox"/> yes	<input type="checkbox"/> no
therapeutic exercise and activities	<input type="checkbox"/> yes	<input type="checkbox"/> no
neuromuscular re-education	<input type="checkbox"/> yes	<input type="checkbox"/> no
massage	<input type="checkbox"/> yes	<input type="checkbox"/> no
manual therapy technique	<input type="checkbox"/> yes	<input type="checkbox"/> no
exams	<input type="checkbox"/> yes	<input type="checkbox"/> no
supports, braces, collars	<input type="checkbox"/> yes	<input type="checkbox"/> no
pillows	<input type="checkbox"/> yes	<input type="checkbox"/> no
nutritional supplements	<input type="checkbox"/> yes	<input type="checkbox"/> no
orthotics	<input type="checkbox"/> yes	<input type="checkbox"/> no
other: _____	<input type="checkbox"/> yes	<input type="checkbox"/> no
other: _____	<input type="checkbox"/> yes	<input type="checkbox"/> 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? yes no
 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: _____

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

1 PATIENT INFORMATION		clinic id	date	
last name		first name		m.i.
age	date of birth	social security #	sex	<input type="checkbox"/> male <input type="checkbox"/> female
Are you here because you were involved in a vehicle collision?			<input type="checkbox"/> yes	<input type="checkbox"/> no
Are you here because you were injured at your place of employment?			<input type="checkbox"/> yes	<input type="checkbox"/> no
Are you here because you were involved in another type of accident?			<input type="checkbox"/> yes	<input type="checkbox"/> no
Who is responsible for this account?				
Will you be using health insurance to supplement payment to our office*?			<input type="checkbox"/> yes	<input type="checkbox"/> no

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

2 INSURANCE COVERAGE				
type of insurance				
<input type="checkbox"/> employee group health plan	<input type="checkbox"/> personal health insurance	<input type="checkbox"/> health savings account	<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid
<input type="checkbox"/> personal injury	<input type="checkbox"/> Workers' Compensation	<input type="checkbox"/> TRICARE/CHAMPUS	<input type="checkbox"/> CHAMPVA	<input type="checkbox"/> 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?		<input type="checkbox"/> yes <input type="checkbox"/> 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	<input type="checkbox"/> male <input type="checkbox"/> female	
relationship to insured		<input type="checkbox"/> spouse	<input type="checkbox"/> dependent	<input type="checkbox"/> 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