FINANCIAL & INSURANCE INFORMATION

Patient Name: _____ **Patient Social Security Number:** _____ **Patient Birthdate:** __/__/__

Primary Insurance Medical Coverage? ❑ Yes ❑ No Dental Coverage? ❑ Yes ❑ No Chiropractic Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (____)_____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: __/__/__ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

Secondary Insurance Medical Coverage? ❑ Yes ❑ No Dental Coverage? ❑ Yes ❑ No Chiropractic Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (____)_____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: __/__/__ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

AGREEMENT TO PAY FOR TREATMENT

The patient and responsible party listed below hereby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization with whom this office has a contractual agreement, the patient and/or responsible party agree to pay all applicable co-payments and deductibles which arise during the course of treatment for the patient. The patient and/or responsible party also agree to pay for treatment rendered to patient which is not considered to be a covered service by third party insurers or payors.

_____ _____
Signature Date

My method of payment will be: ❑ Cash ❑ Check ❑ Credit Card. Credit Card #: _____ Expiration Date: _____

_____ _____
Signature Date

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in my being unable to receive additional services except for emergencies or when there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

RELEASE AND STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO PROVIDER

I, (We), the undersigned patient and/or responsible party hereby jointly authorize this office, its agents/employees to release and disclose all or any part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges.

I, (We), authorize the release and disclosure of any and all of my medical records to any other entity, including, but not limited to, referring physicians, hospitals, or other health care providers, which may be of assistance in the opinion of this office, in providing for the treatment of the patient.

I, (We), authorize the release of records necessary to assist in the reimbursement of benefits to which I, (We) may be entitled. I, (We) authorize this office and/or its employees to release, via fax machine, medical records which are needed in order to provide patient with the most appropriate medical care.

I, (We), authorize and request that payment of any third-party or insurance company benefits be made to this office for any services furnished to patient. The signatures furnished below shall suffice for all insurance forms on a continuing basis.

_____ _____
Signature of Patient Date

_____ _____
Signature of Insured Date