INSURANCE INFORMATION

Are your conditions due to an auto accident or job related injury? Yes _____ No _____

Do you have Health Insurance? Yes _____ No _____

If yes, Name of the Company _____ *Please provide card to front desk for benefit check*

Does Medicare cover you? Yes _____ No _____ *Please provide card to front desk for benefit check*

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, and fees for professional services rendered me will be immediately due and payable.

I, _____, hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid for by my insurance company (if offered at this office).

Patient's Signature _____

Date _____

Guardian or Spouse's Signature _____

Doctor's Signature _____