

APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. PLEASE PRINT.

Today's Date _____

Full Name _____ Nickname _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone:() _____ Work Phone:() _____ Cell Phone:() _____

Birthdate: ____ / ____ / ____ Your SS #: ____ - ____ - ____ Marital Status S M W D

No. of Children: _____ Years on Job: _____ Email: _____

Your Employer: _____ Occupation: _____

Address: _____ City: _____

State: _____ Zip: _____ Name of Spouse/Parent: _____

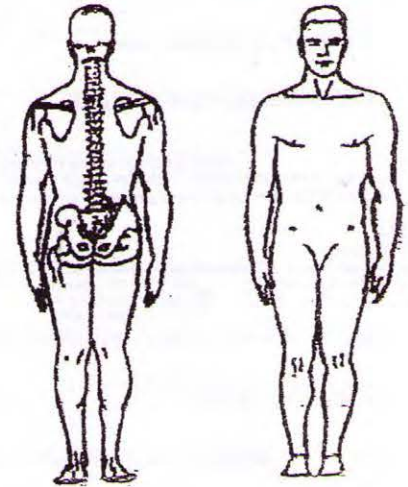
Who referred you to our clinic? _____

COMPLETE THESE DIAGRAMS

Mark areas of injury or discomfort on the figures to the left. Indicate the Degree of pain using a scale of 1 (discomfort) to 10 (extreme pain). Describe The type and frequency of pain, and any activity which brings on the pain. For example, dull, sharp, consistent, off & on, when standing, sitting, etc

CHIEF COMPLAINTS

Conditions you are being treated for or are experiencing:



How payment will be made:

Type of Insurance:

Cash Credit Card Check Health Insurance Worker's Comp Auto Ins. Policy

Have you ever been in an Auto Accident? Past YR Past 5 YRS Over 5 YRS NEVER

Is your condition due to an Accident? Yes No Date of Accident: _____

Type of Accident? Auto Work/On Job At Home Other _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on 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, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedure to be performed. The patient also agrees that he is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient / Guardian Signature: _____ Date: _____

Notice to our new patients: Payment for services is due at each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing doctor. **Insurance Cases:** on all insurance assignments the deductible should be met in the beginning unless prior arrangements are made.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

* Signature Only *

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1. MEDICARE <input type="checkbox"/> (Medicare #) <input type="checkbox"/> MEDICAID <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1)																																																																																																																																																																																																																																																																																																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																																																																																																																																																																																																																																																																							
5. PATIENT'S ADDRESS (No., Street), CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street), CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()																																																																																																																																																																																																																																																																																							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR FECA NUMBER																																																																																																																																																																																																																																																																																							
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																																																																																																																																																																																																																																																																																							
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____										b. EMPLOYER'S NAME OR SCHOOL NAME																																																																																																																																																																																																																																																																																							
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME																																																																																																																																																																																																																																																																																							
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																																																																																																																																																																																																																																																																																							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																																																																																																																																																																																																																																																																																																	
* SIGNED _____ DATE _____										* SIGNED _____ DATE _____																																																																																																																																																																																																																																																																																																	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																																																																																																																																																																																																																																																																							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																																																																																																																																																																																																																																																							
17b. NPI _____										19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____																																																																																																																																																																																																																																																																																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.										23. PRIOR AUTHORIZATION NUMBER																																																																																																																																																																																																																																																																																							
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY										B. PLACE OF SERVICE										C. EMG										D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER										E. DIAGNOSIS POINTER										F. \$ CHARGES										G. DAYS OR UNITS										H. EPSDT Family Plan										I. ID. QUAL.										J. RENDERING PROVIDER ID. #																																																																																																																																																																																																																	
1										2										3										4										5										6										7										8										9										10										11										12										13										14										15										16										17										18										19										20										21										22										23										24										25										26										27										28										29										30									
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ _____										29. AMOUNT PAID \$ _____										30. BALANCE DUE \$ _____																																																																																																																																																																																																																																																									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH # ()																																																																																																																																																																																																																																																																																							
SIGNED _____ DATE _____										a. _____ b. _____										a. _____ b. _____																																																																																																																																																																																																																																																																																							

PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION