Personal Info. and Financial Responsibility

Name _____ Social Security Number_____-_____-_____

Preferred Language_____ Race_____ Ethnicity_____

Address_____ City_____ State_____ Zip_____

Home # (_____) _____ Work #(_____)_____ Cell # (_____)_____

Email _____ How did you find us? _____

Occupation_____ Employer_____ Marital Status: M S W D

Spouse's Name_____ Spouse's Phone #(_____)_____

INSURANCE INFORMATION:

Do you have health insurance? Yes No Are you covered by Medicare? Yes No

If yes, Please provide your insurance card and driver's license / picture ID to be copied to enable billing.

Is your condition due to an auto accident or job related injury? Yes No

ELIGIBILITY GUARANTEE AND ASSIGNMENT OF BENEFITS:

I, _____ hereby certify that I am eligible for chiropractic benefits offered by

_____ as of _____.
(Name of Health Plan) (Today's Date)

I understand and agree that health and accident policies are an arrangement between an Insurance carrier and myself. Furthermore, I understand that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. However, I also understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.
If the information I have provided Is not true or I am not eligible for coverage under the terms of my health insurance, managed care plan or Medicare, I am liable for all services rendered.
I understand that interest, in the amount of 2% will be added to my balance if payment is not received within thirty (30) days of bill date and will continue to accrue until my balance is paid in full ($0). I understand and agree to pay any and all attorney and collection fees, in the event it is necessary to forward my account to an attorney for collection proceeding.

ASSIGNMENT OF BENEFITS:

I authorize the release of any health information necessary to process insurance claims from this office.

A photo copy of this authorization shall be as effective and valid as the original.

I authorize and request my insurance company, managed care company and/or Medicare to make all medical benefits payments, otherwise payable to me, directly to Nelson Gregory, D.C., c/o Richmond Chiropractic Solutions.

Patient Signature_____ Date_____

Guardian or Spouse's Signature_____