

Elite Chiropractic Health & Rehabilitation

Will you be using health insurance to supplement payment to our office? yes no

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

1. INSURANCE COVERAGE		
Type of insurance		
<input type="checkbox"/> Employee Group Health Plan	<input type="checkbox"/> Personal Health Insurance	<input type="checkbox"/> Health Saving Account
<input type="checkbox"/> Personal Injury	<input type="checkbox"/> Worker's Compensation	<input type="checkbox"/> Medicare
Primary insurance company	Primary ins ID#	Primary ins group#
Secondary insurance company	Secondary ins ID#	Secondary ins group#

2. INSURANCE INFORMATION		
Are the insured and patient the same person? <input type="checkbox"/> yes <input type="checkbox"/> no		
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 Injured <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.

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. As the patient/guardian, I am ultimately responsible for all charges incurred.	
_____	_____
Patient or guardian signature	Date

3. BENEFITS ASSIGNMENT	
I authorize that payment of charges be made directly to the doctor(s) of the clinic. This authorization includes:	
<ol style="list-style-type: none"> 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

4. 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 benefits to me or my assignee.	
_____	_____
Patient or guardian signature	Date