ROOTS WELLCARE, P.A.
570 Asbury Street, Suite 108
St. Paul MN 55104
651-310-0000

FINANCIAL INFORMATION

Patient Name _____ Date_____
Date of birth_____
Employer_____ City_____

Payment Arrangements
__☐__ Blue Cross Blue Shield
__☐__ Cash/self-pay
__☐__ Cigna
__☐__ Health Partners
__☐__ Medica
__☐__ Medicare
__☐__ Motor Vehicle Accident benefits
__☐__ Other insurance (name: _____)
__☐__ Preferred One
__☐__ UCare
__☐__ Workers' Compensation injury benefits

Primary Insurance Company information:
Name of Insured (Policyholder)_____

Policyholder's date of birth_____ Effective date of coverage_____

Please bring your insurance card and driver's license/state identification card with you to your appointment.

For Motor Vehicle Accident injuries, please complete the following:

Name of Policyholder_____ Relationship to patient_____
Claim #_____
Claim Adjuster name_____ Phone_____
Has an Application for Benefits form been completed? Yes No (circle one)
Date of Injury_____
Have you retained an attorney? Yes No (circle one)
Attorney name_____ Phone_____
Were police contacted after the accident? Yes No (circle one)
Do you have the police report? Yes No (circle one)
Were you at fault in the accident?_____

For Work-Related injuries, please complete the following:

Date of Injury_____
Have you retained an attorney? Yes No (circle one)
Attorney name_____ Phone_____
Has your injury been reported to your employer? Yes☐ No☐ (circle one) Date reported_____
Has a First Report of Injury been completed? Yes☐ No☐ Unsure☐ (circle one)

ASSIGNMENT OF INSURANCE PROCEEDS

If you have insurance, please sign this assignment of benefits agreement. By agreeing to this assignment, Roots WellCare, P.A. will direct your insurance company to make any payments for your chiropractic, physiotherapy, physical rehabilitation, x-rays, diagnostic testing or any other reimbursable treatment or evaluations you receive to our clinic directly.

In exchange for services and supplies rendered, I do assign to Roots WellCare, P.A. any insurance proceeds, including accident and health insurance, auto insurance benefits and bodily injury claim awards up to the amount of any unpaid balance on my account. In giving this assignment, I acknowledge that I will be responsible for the amount of any unpaid balance with interest as allowed by law.

Signature_____ Date_____

RECORDS RELEASE AUTHORIZATION To: Roots WellCare, P.A.

You are authorized to release any information contained in my file to any insurance company, attorney, adjuster or member of my office staff, including any contracted billing services representing Roots WellCare, P.A. or its associates, in order to process any claim for reimbursement of charges incurred for supplies furnished to me or services rendered to me by you or another member of the clinic. I further authorize phone contact with the above listed third parties should phone contact be required for the purpose of obtaining payment for charges outstanding.

Signature_____ Date_____

COST OF COLLECTIONS (Collection Agency or Attorney)

I understand that if I fail to pay my account as agreed, Roots WellCare, P.A. may, after reasonable attempts to obtain payment, place my account for collection. I understand that if my account is placed for collection with an agency, payments made after collection agency placement result in an agency fee of 1/3 of any amount paid. If my account is placed for collection, I agree to pay Roots WellCare, P.A.'s costs of a collection up to 1/3 of the amount recovered.

Signature_____ Date_____