

FINANCIAL DATA

Patient Name _____ Date _____
Employer _____ City _____
Social Security # _____ Birth date: _____

Payment Arrangements

_____ Cash/self-pay
_____ Medicare
_____ Blue Cross Blue Shield
_____ Other insurance (name: _____)
_____ Motor Vehicle Accident benefits
_____ Workers' Compensation injury benefits
_____ Other _____

Primary Insurance Company Information:

Name of Insured (Owner of policy) _____

Insured's Birth date _____ Effective date of coverage _____

ID #/Policy # _____ Group # _____

Please bring your insurance card with you to your appointment. We will photocopy it!

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 the clinic, 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 _____

For Motor Vehicle Accident injuries, please complete the following:

Name of Policyholder _____ Relationship to client _____

Claim # _____ Claim Adjuster's Name/Phone _____

Has an Application for Benefits (AFB) form been completed? Yes No

Date of Injury _____ Do you have an attorney? Yes No

Attorney Name _____ Attorney phone _____

Were the police contacted after the accident? Yes No

Do you have the police report? Yes No If no, have you ordered it? _____

Were you at fault in the accident? _____

For Work-Related injuries, please complete the following:

Date of Injury _____ Do you have an attorney? Yes No

Attorney Name _____ Attorney phone _____

Has the injury been reported to your employer? Yes No

Has a First Report of Injury been completed? Yes No Unsure