
# INSURANCE INFORMATION

How will you be paying for today's visit? ☐ Cash ☐ Check ☐ Credit Card

Please check all insurance coverage that may be applicable in this case:

☐ Major Medical ☐ Auto Accident ☐ Worker's Compensation ☐ Medicare ☐ Flex Plans ☐ Other_____

Insurance Carrier Name_____
Group #_____ Policy #_____
Is the insurance policy in your name? ☐Y ☐N (If No, please fill out the following for the insured)
Insured's First Name_____ M.I._____ Last Name_____
Insured's Address_____ Unit #_____
City_____ State_____ Zip_____
Insured's Birth Date (mm/dd/yyyy)_____ Sex: ☐M ☐F
Insured's Social Security #_____
Your relation to the Insured_____

**Auto Accident & Worker's Compensation Patients:** Type: ☐ Auto Accident ☐ Worker's Compensation
Insurance Carrier Name_____
Insurance Carrier Address_____
Insurance Carrier City, State, Zip_____
Date of Injury_____ Claim Number_____
Adjuster's Name_____ Adjuster's Telephone(____)_____

**Authorization and Release:**
I authorize payment of insurance benefits directly to this chiropractic office. I authorize the doctor to release all information necessary to communicate with personal healthcare providers, payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Patient Name (Print):_____ Date:_____

Patient Signature:_____