# _____ Chiropractic

## Patient Information

Patient Last Name _____First Name_____

Address_____City_____State_____Zip_____

Phone#(____)_____DOB_____/_____/_____Sex M F SSN_____

Marital Status: M S D W File#_____

### INSURANCE INFORMATION

Acct Type ____ ID#_____ Insured_____
Group#_____ Insured DOB_____/_____/____ Relation_____ ___

Group Name_____ _____ Carrier_____

Address_____ City_____State_____ Zip_____

Phone #_____Primary_____Secondary_____

1st visit_____/_____/_____

## VERIFICATION OF INSURANCE BENEFITS

Spoke with_____ Phone(_____)_____Date____/_____/_____

Chiro coverage: Y N ___ in network or ___out of network Effective date ____/_____/_____

Deductible $_____ Met? _____ What % does policy pay?_____% X-Rays_____% Office Visits _____% Manipulations _____% Modalities _____% Physical Therapy_____% Copay $_____

Total # visits allowed_____ Payment limitations_____ Prior Auth required: Y N

Coverage for: _____calendar year or _____contract year

Verified by _____

**FINANCIAL ARRANGEMENTS** (*the portion patient is responsible*) _____

**DIAGNOSIS 1)_____2)_____3)_____4)_____**