Name:_____ Date of Birth: _____ SS# _____

Email: _____ FREE Monthly Wellness Newsletter Y N

INSURANCE INFORMATION

Insurance Company _____ Policy# _____

Insured's Name _____ Patient relationship to the insured ☐ Self ☐ Spouse ☐ Child

Insurance Company phone number _____

Secondary Policy ☐ Yes ☐ No If Yes, name of Secondary _____

Secondary Policy # _____

Secondary Company phone number _____

IF MOTOR VEHICLE RELATED PLEASE ANSWER THE FOLLOWING

Insurance Company: _____ Policy Holder of Vehicle: _____

Claim # (If Known) _____ Policy # (If Known): _____

Date of Accident: _____ Attorney (If Known): _____

ASSIGNMENT OF BENEFITS (EVERYONE MUST COMPLETE)

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Touch of Life Chiropractic and its Doctors, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance, except in instances were No-Fault or Workers' Compensation fee schedules apply. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of my signature on all insurance submissions.

Signature of responsible party: _____ Date: _____

MEDICARE ASSIGNMENT OF BENEFITS/RIGHTS FOR DIRECT PAYMENT TO DOCTOR

I request that payment of authorized Medicare benefits be made on my behalf to Touch of Life Chiropractic or its Doctors, for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of responsible party: _____ Date: _____