Insurance Information

Who is responsible for this account?_____ **Relationship to patient**_____
Insurance Company _____ **Group#**_____ **Policy ID #**_____
Insurance is through what Business or Group?_____
Subscriber's Name_____ **Birthdate**_____ **SS#**_____
Subscriber's Address_____ **City**_____ **State**_____ **Zip**_____
Subscriber's Home Phone( )_____ **Work Phone( )**_____ **Cell Phone( )**_____
Is Patient covered by additional insurance? Yes No
Insurance Company _____ **Group#**_____ **Policy ID #**_____
Subscriber's Name_____ **Birthdate**_____ **SS#**_____
Relationship to patient_____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr Carmen M Clemenson 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 insurance. I authorize the use of my signature on all insurance submissions.

Dr Carmen M Clemenson may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor.

_____ Date_____
Signature of Patient, Parent, Guardian or Personal Representative

_____ Relationship to Patient_____
Please print name of Patient, Parent, Guardian or Personal Representative