

INSURANCE INFORMATION

As a courtesy, we will contact your insurance company to verify any in or out of network benefits that may be available to you through your plan. Please note that this does not guarantee payment by your insurance and you are responsible for all charges that apply if your insurance fails to pay correctly and/or in a timely manner. If we need to bill insurance we will charge according to the government published data and guidelines from the Centers for Medicare and Medicaid. This increased charge is due to our increased costs in processing insurance as well as waiting on payment to be received.

Patient Name: _____ Patient Date of Birth: _____

Subscriber Name _____ Subscriber's Date of Birth: _____

Insurance Company: _____ Subscriber # or SS: _____

Employer Name: _____ Group #: _____

Subscriber Relationship to Patient: _____

Subscriber's Address if different than patient: _____

Phone Number: _____



COPY OF INSURANCE CARD – FRONT AND BACK



I authorize the release of any medical information necessary to process this claim. I also authorize all claims to be sent directly to my insurance company and I authorize payment to be made directly to Active Chiropractic Wellness Center. I also agree to pay for any copay, deductible, or percentages designated as my responsibility. In the event that I should receive payment for these services, I agree to promptly remit payment to Active Chiropractic Wellness Center. I also accept personal responsibility for any balance due.

Patient or Responsible Party Signature

Date

