Good Health Naturally

Clear Choice Chiropractic of Niles, PC

CONFIDENTIAL PATIENT INFORMATION

Name____ Birthday_____________________________

Address_______________________________________ City_________________________________

State____________ Zip Code_____________________ Phone_______________________________

Cell Phone___________________ Marital Status: S M W D SS#:____________________

Number of Children______ Sex: M F If Female, are you pregnant? YES NO

Email____

Occupation___________________________ Employer______________________________________

Work Address____

Insurance Carrier_________________________ Phone Number_______________________________

Policy Number___________________________ Group Number______________________________

Subscriber_______________________________ How did you hear about us?___________________

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I here by instruct and direct my insurance company and or attorneys to make payment for services rendered directly to :

Clear Choice Chiropractic
P.O. Box 725 Niles, MI 49120

If my insurance carrier prohibits direct payment to this clinic, then I hereby also instruct and direct my insurance company to make the check out to me and mail it as follows:

Clear Choice Chiropractic
P.O. Box 725 Niles, MI 49120

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee and I further agree I will pay, in a current manner, any balance of said professional services charges over and above this insurance payment.

A photocopy of this agreement shall be considered as effective and valid as the original document.

I authorize the release of any information pertinent to my case to all insurance carriers, adjusters or attorneys directly involved with my case.

Signature______________________________ Date_______ Witness Signature_________________________ Date_________