DrOhmyback.com

Account Information **PEACE OF MIND, BALANCED BODY ™**

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you. We want your visit with us to be comfortable, helpful and educational.

Confidential health information

1 PATIENT INFORMATION

Clinic id		Date	
Last name	First name		m.i.
age	Date of birth / /	SSN _ _	Sex male female

Are you here because you were involved in a vehicle collision?	yes	no
Are you here because you were injured at your place of employment?	yes	no
Are you here because you were involved in another type of accident?	yes	no
Who is responsible for this account?		
Will you be using health insurance to supplement payment to our office*?	yes	no

*** If YES, please complete the INSURANCE COVERAGE and INSURED INFORMATION sections of this form.**

2 INSURANCE COVERAGE

Type of insurance

Employee group health plan	Personal health insurance	Health savings account	Medicare	Medicaid
Personal injury	Workers' Compensation	TRICARE/CHAMPUS	CHAMPVA	FECA

	Insurance Company	Insurance ID	Insurance Group ID
Primary			
Secondary			

3 INSURANCE INFORMATION

Last name	First name			m.i.
street				
city		state	zip	
age	date of birth	Last 4 digits of SSN	sex	male female
Relationship to insured	spouse	dependent	Other	

We are here to service our patients the best way we know how. We understand the value of health insurance. However, because health insurance plans are intended only to supplement out of pocket expenses for care, it may not cover all the care you need. We will verify your applicable insurance benefits and report the supplemental coverage to you.

Our relationship is with each patient individually, not the insurance companies. If we believe that we may be able to help you and we accept your case, our recommendations will be based on what we believe is best for you – supported by our experience. We take great care in making our services affordable regardless of health insurance coverage.

I understand agree to the following:

- **There is no guarantee that my health insurance plan or policy will pay for all or part of my care.**
- **I will be informed of fees and charges before the associated procedure or service is performed.**
- **As the patient or guardian of a patient, I am ultimately responsible for all charges incurred from services rendered.**

By my eSignature below, I certify that I have read, fully understand and accept all terms of the foregoing statement. Please signify your acceptance by entering the information requested in the fields below.

Full Name: Date: / /

1 BENEFIT ASSIGNMENT

By my eSignature below, I authorize that payment of charges be made directly to the doctor(s) of this clinic. This authorization includes:

1. **All insurance reimbursement of services rendered, including those which may be payable to me under my insurance plan or policy.**
2. **Amounts owed on my behalf from proceeds of any settlement related to my case.**

Patient or guardian Full Name   Date / /

2 INFORMATION RELEASE

By my eSignature below, I authorize the release of any necessary information to my insurance companies, pre-paid health plan or account, or government managed health plan to request payment benefits to me or my assignee.

Patient or guardian Full Name   Date / /

INSURANCE COVERAGE

OFFICE USE ONLY – Please Do Not Write In This Box

Is this a Workers' Comp case?	yes	no	Is this an **Auto Collision** or **Personal Injury** case?	yes	no
Has the injury been reported?	yes	no	Has it been reported to the insurance company?	yes	no
Name:			Has an application for benefits been filed?	yes	no
Title:			Did the police write a report?	yes	no
Is patient currently employed at place of injury?	yes	no	Is auto or PI insurance primary?	yes	no
Name of person authorizing care:			Agent name and contact info:		

Does the plan cover the following services?	yes	no	Does the plan have a deductible?	yes	no
Chiropractic adjustments			Amount for an individual:		
Modalities:			Amount for the family:		
Hot/clod packs			Amount currently met:		
Mechanical traction			When does the deductible renew?		
Electric stimulation			Do charges for diagnostic tests apply to deductible?	yes	no
Ultrasound			What is the co-pay after the deductible is met?		
Therapeutic exercise and activities			What is the maximum yearly benefit?		
Neuromuscular re-education			What is the yearly visit cap?		
Massage			Does the company assign benefits to the doctor?	yes	no
Manual therapy technique			Are any special forms required to file claims?	yes	no
Exams			What is the name of the person that you spoke with?		
Support, braces, collars			Last:		
Pillows			First:		
Nutritional supplements			ID # Extension:		
Orthotics			Notes:		
Other:					
Other"					