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

Has the injury been reported? ☐ yes ☐ no

Name: _____

Title: _____

Is patient currently employed at place of injury? ☐ yes ☐ no

Name of person authorizing care: _____

Is this an **Auto Collision** or **Personal Injury** case? ☐ yes ☐ no

Has it been reported to the insurance company? ☐ yes ☐ no

Has an application for benefits been filed? ☐ yes ☐ no

Did the police write a report? ☐ yes ☐ no

Is auto or PI insurance primary? ☐ yes ☐ no

Agent name and contact info: _____

Does the plan cover the following services?	yes	no
Chiropractic adjustments	☐	☐
Modalities:		
Hot/clod packs	☐	☐
Mechanical traction	☐	☐
Electric stimulation	☐	☐
Ultrasound	☐	☐
Therapeutic exercise and activities	☐	☐
Neuromuscular re-education	☐	☐
Massage	☐	☐
Manual therapy technique	☐	☐
Exams	☐	☐
Support, braces, collars	☐	☐
Pillows	☐	☐
Nutritional supplements	☐	☐
Orthotics	☐	☐
Other:	☐	☐
Other"	☐	☐

Does the plan have a deductible? ☐ yes ☐ no

Amount for an individual: _____

Amount for the family: _____

Amount currently met: _____

When does the deductible renew? _____

Do charges for diagnostic tests apply to deductible? ☐ yes ☐ no

What is the co-pay after the deductible is met? _____

What is the maximum yearly benefit? _____

What is the yearly visit cap? _____

Does the company assign benefits to the doctor? ☐ yes ☐ no

Are any special forms required to file claims? ☐ yes ☐ no

What is the name of the person that you spoke with?

Last: _____

First: _____

ID # _____ Extension: _____

Notes: _____

Print Send