DelPlato Chiropractic, PC

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Insurance Billing

Primary

(Patient's Insurance Information)

Insurance Co. Name _____
Billing Address _____
Phone # (to verify eligibility) _____
Name of Insured _____
ID/Policy # _____
Group or Claim # _____
Insurance Agent's Name _____
And Phone # _____

I hereby authorize DelPlato Chiropractic, PC to furnish the insured's insurance company all information concerning my present claim.

Signature _____
Date _____

Other Insurance

Insurance Co. Name _____
Billing Address _____
Phone # (to verify eligibility) _____
Name of Insured _____
ID/Policy # _____
Group or Claim # _____
Insurance Agent's Name _____
And Phone # _____

I hereby authorize DelPlato Chiropractic, PC to furnish the insured's insurance company all information concerning my present claim.

Signature _____
Date _____

Assignment and Release

I certify that I, and/or my dependent(s), have Insurance coverage with _____(insurance co.) and assign directly to Dr. DelPlato all insurance benefits, if any, otherwise payable to me for service 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. DelPlato 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. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

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

_____ _____
Date Relationship to Patient