

# Chiropractic Registration and History

## Patient Information

Date \_\_\_\_\_

Patient ID # \_\_\_\_\_

Patient Name \_\_\_\_\_

Last Name

First Name

Middle Initial

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_

Sex:  M  F Age \_\_\_\_\_

Birth Date \_\_\_\_\_

Married  Widowed  Single  Minor

Separated  Divorced  Partnered for \_\_\_\_\_ years

Occupation \_\_\_\_\_

Patient Employer/School \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Employer/School Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Spouse's Birth Date \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## Phone Numbers

Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Alt. Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

### IN CASE OF EMERGENCY, CONTACT

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Alt. Phone ( \_\_\_\_\_ ) \_\_\_\_\_

## Patient Condition

Reason for Visit \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

Mark an X on the picture to the right where you continue to have pain, numbness or tingling. ►

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  Other

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your:  Work  Sleep  Daily Routine  Recreation

Activities or movements that are painful to perform:  Sitting  Standing  Walking  Bending  Lying Down

## Insurance

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birth Date \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

\_\_\_\_\_ and assign directly to  
Name of Insurance Company(ies)

Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services 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.

The above-named doctor 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

## Accident Information

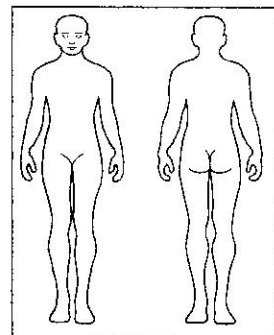
Is condition due to an accident?  Yes  No Date \_\_\_\_\_

Type of Accident:  Auto  Work  Home  Other

To whom have you made a report of your accident?

Auto Insurance  Employer  Worker Comp.  Other

Attorney Name (if applicable) \_\_\_\_\_



# Health History

What treatment have you already received for your condition?  Medications  Surgery  Physical Therapy

Chiropractic Services  None  Other \_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition \_\_\_\_\_

Date of Last: Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_

Spinal Exam \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ Urine Test \_\_\_\_\_

Dental X-Ray \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

Mark box "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually Transmitted Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____	
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Please mark in each column which boxes best describe your activities:

## EXERCISE

- None
- Moderate
- Daily
- Heavy

## WORK ACTIVITY

- Sitting
- Standing
- Light Labor
- Heavy Labor

## HABITS

- Smoking
- Alcohol
- Coffee/Caffeine Drinks
- High Stress Level

Packs/Day \_\_\_\_\_  
 Drinks/Week \_\_\_\_\_  
 Cups/Day \_\_\_\_\_  
 Reason \_\_\_\_\_

Are you pregnant?  Yes  No

Due Date \_\_\_\_\_

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

## Medications

## Allergies

## Vitamins/Herbs/Minerals

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Pharmacy Phone (\_\_\_\_\_) \_\_\_\_\_

Pharmacy E-mail (\_\_\_\_\_) \_\_\_\_\_



# ARNDT FAMILY CHIROPRACTIC

## PREGNANCY INTAKE FORM / CASE HISTORY / CONSENT

### Personal Information

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

### Prenatal Birth History

Is this your first pregnancy? Yes / No

How many previous births have you had? \_\_\_\_\_ How many previous pregnancies? \_\_\_\_\_

Do you smoke or drink alcohol? \_\_\_\_\_ If so, how regularly? \_\_\_\_\_

Have you had any evaluation procedures (ultrasound, amniocentesis, chorionic villus sampling)? \_\_\_\_\_

If "Yes", please list dates, frequency and reason for these procedures: \_\_\_\_\_

How has your diet been during this pregnancy? \_\_\_\_\_

Have you experienced any stressful events during this pregnancy? \_\_\_\_\_

What is most significant fears associated with this birth? \_\_\_\_\_

### Previous Birth History

Place of birth(s) birth at: Home/ Hospital / Birth Center - Name of Hospital/Center \_\_\_\_\_

Childbirth Caregivers(s): OB/GYN \_\_\_\_\_ Doula \_\_\_\_\_ Midwife \_\_\_\_\_

Position of Delivery (circle): Lithotomy Position (on back/feet up) / Squatting Bar / On You Side /  
Kneeling / Other \_\_\_\_\_ / Please include other if Applicable:

Was labor induced? (contractions were stimulated intravenously *prior* to the natural onset of labor)  
Yes / No / Unknown - If "Yes", specify type: Pitocin / Prostaglandin Gel (applied to cervix) / Unknown

Were your membranes ruptured by your care provider? Yes / No / Unknown

Were contractions stimulated intravenously with Pitocin *once* labor started: Yes / No / Unknown

Did you receive any pain medications or anesthesia? Yes / No / Unknown  
Please specify type used \_\_\_\_\_

If you had an Epidural, how many centimeters were you dilated when it was administered? \_\_\_\_\_

Did you experience back pain during labor? Yes No / Unknown

Did you deliver vaginally? Yes / No

Baby presentation at time of delivery: Normal / Posterior ("sunny side up") / Brow / Facial / Occipital / Breech / Unknown

If Breech, specify type: Footling / Frank / Complete / Kneeling

Was there any visible injury to your baby? Yes / No / Unknown

If so, to where on your baby was the injury sustained? \_\_\_\_\_

Did your Caregiver assist delivery with his/her hands? Yes / No / Unknown

Was there any turning of the neck, or traction (pulling) applied to the neck? Yes / No / Unknown

Was vacuum extraction used to facilitate the birth? Yes / No / Unknown

If "Yes", was there any visible signs of injury to your baby? Yes / No / Unknown

If "Yes", where was the injury sustained? \_\_\_\_\_

Were forceps used to facilitate the birth? Yes / No / Unknown

If "Yes", was there any visible signs of injury to your baby? Yes / No / Unknown

If "Yes", where was the injury sustained? \_\_\_\_\_



# ARNDT FAMILY CHIROPRACTIC

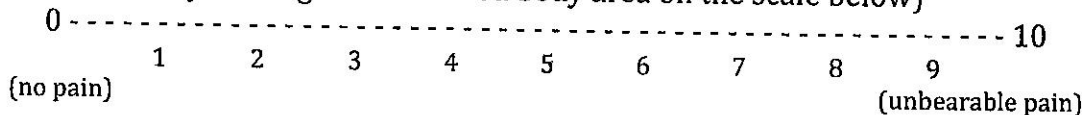
## SUBJECTIVE ANALYSIS FORM

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_ Initial or Re-Exam \_\_\_\_\_

### Visual Analog Scale

(please indicate the pain level you are currently experiencing by writing each involved body area on the scale below)



Total all Pain Levels: \_\_\_\_\_

### Activities of Daily Living

People with spinal pain may find that certain activities are restricted or difficult to do.

Please check all activities that you find difficult to do **now**:

- |  |   |
|--|---|
| <input type="checkbox"/> Sleep through the night             | <input type="checkbox"/> Cross legs                                       |
| <input type="checkbox"/> Get out of bed                      | <input type="checkbox"/> Walk one mile                                    |
| <input type="checkbox"/> Bathe yourself                      | <input type="checkbox"/> Stand for 30 mins.                               |
| <input type="checkbox"/> Wash, comb or dry hair              | <input type="checkbox"/> Travel on journeys that take over one hour       |
| <input type="checkbox"/> Bend over a sink for 10 mins.       | <input type="checkbox"/> Push or pull vacuum cleaner or lawn mower        |
| <input type="checkbox"/> Go to the bathroom                  | <input type="checkbox"/> Carry laundry basket, groceries or a small child |
| <input type="checkbox"/> Put on socks, shoes or clothing     | <input type="checkbox"/> Wash windows or walls                            |
| <input type="checkbox"/> Walk up one flight of stairs        | <input type="checkbox"/> Bend over to clean bathtub                       |
| <input type="checkbox"/> Walk down one flight of stairs      | <input type="checkbox"/> Shovel snow or dirt                              |
| <input type="checkbox"/> Crawl on all fours                  | <input type="checkbox"/> Use pencil, scissors, screwdriver or pliers      |
| <input type="checkbox"/> Turn a door knob                    | <input type="checkbox"/> Lift a heavy suitcase (approx. 40 pounds)        |
| <input type="checkbox"/> Open a heavy door                   | <input type="checkbox"/> Reach in front or overhead to high shelves       |
| <input type="checkbox"/> Sit in a chair for 30 mins.         | <input type="checkbox"/> Enjoy hobbies or social activities               |
| <input type="checkbox"/> Sit and work at a desk for one hour | <input type="checkbox"/> Enjoy sexual activities                          |
| <input type="checkbox"/> Get up from a low seat              |   |

Total # ADL items checked \_\_\_\_\_

Subjective Total \_\_\_\_\_

Check any of the following conditions you are **currently** experiencing:

- Neck or back weakness
- Restricted movement of neck or back
- Persistent tender areas in muscles around neck or back
- "Catch" or "Kink" in neck or back

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



# ARNDT FAMILY CHIROPRACTIC

## NON-COVERED CHIROPRACTIC SERVICES CONSENT FORM

This Consent is to clarify our policy regarding non-covered services.

Non covered services are those procedures and services deemed not medically necessary by the insurer or their administrator. In this office, our major concern is to assist you in maintaining overall good health. The health plan's chiropractic and therapy benefits are for acute, active therapeutic care. Once your symptoms have been reduced to a level of supportive or maintenance care, or you have utilized all your insurance allowed visits or coverage, the responsibility for payment of services is that of you, the patient.

We believe it is beneficial for the patient to continue supportive or maintenance care on a regular basis in order to maintain correction. If you elect to continue care, please be aware that you are responsible for the continued payment of our services.

If you have any questions regarding your chiropractic insurance benefits you should contact your health plan through your customer service representative.

It is very important that you understand your financial choices in order to alleviate any misunderstanding or confusion between all parties. A list of our *approximate* costs is enclosed in this packet for your review and signature. You also can ask for a separate copy for your reference. We strive to explain to you in advance our costs regarding any procedures or treatments.

We ask that you please sign this Consent Form acknowledging receipt of the above information and your financial responsibility. A copy of this Consent will be maintained in your file should any questions or concerns arise.

As always, it is our mission to provide you with the highest quality of care. Thank you for choosing Arndt Family Chiropractic for your chiropractic care. We look forward to working with you.

### **DISCLOSURE STATEMENT:**

I have read and understand the above information. I understand and accept that I will be financially responsible for full payment of any and all non-covered services.

×

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date

×

\_\_\_\_\_  
Patient Signature



# ARNDT FAMILY CHIROPRACTIC

## FINANCIAL AGREEMENT

The purpose of this Agreement is to clarify the financial aspects of your chiropractic care at Arndt Family Chiropractic. By your reviewing this information and signing below, we can devote our efforts to effectively helping you to achieve the best results – in the shortest amount of time.

### Services:

Our fees vary based upon the severity of your condition(s) and the amount of time required to achieve the best result. Below are the most common services that we provide.

<u>Procedure</u>	<u>Purpose</u>	<u>When Performed</u>	<u>Fee</u>
Consultation	Tour the office, meet the doctor & staff. Discuss your issue(s) and health history.	Initial Visit	N/C
Examination(s)	Accurately determine the nature of your issue(s) and determine best course of action.	Initial Visit – Repeat every 10 <sup>th</sup> to 15 visit	\$50 - \$95
X-Ray(s)	Visualize the location of spinal pathologies and confirm other examination findings	If necessary – 1 <sup>st</sup> Visit, Re-injuries. As needed for progress exams.	\$25 - \$75 Per Region
Evaluation/ Management/ Adjustment(s)	Assess and evaluate Patient's health, determine appropriate course of care and reduce the Vertebral Subluxation Complex, Stabilize spine or joint problems.	Every Visit	\$30 - \$60
Therapy	Reduce inflammation and swelling, enhance the healing process and help to provide relief	As indicated by exam or office visit	\$16 – \$28
Laser Therapy	Reduces short term inflammation. Lowers risk of arthritis. Provides deep tissue therapy.	As indicated by exam	\$20 - \$90

### Forms of Payment:

If you have health insurance, managed care, Medicare, Medicaid or personal injury coverage, we will submit the necessary paperwork and billing. Some exceptions may apply. You are responsible for any deductibles, co-pays or charges not covered by your insurance company.

You may also choose the option of paying on the day of service and receiving a day of service discount. We accept cash, personal checks, Visa, Master Card, Discover and AMEX.

### Questions:

Please do not hesitate to ask should you have any questions about this Agreement. If your ability to comply with the provisions of this Agreement changes, please let us know. We are here to help.

### Patient Agreement:

I have read, understand, agree to and have received a copy/declined a copy (*please indicate*) of this Agreement.

X \_\_\_\_\_  
Patient/Responsible Party Signature                      Date                      Office Representative



# *ARNDT FAMILY CHIROPRACTIC*

## OFFICE POLICY DEFINITIONS

Please initial all that apply:

— **Payment of Your Bill**

It is the ultimate responsibility of the Patient/Guarantor to pay or provide third-party coverage for payment of all services received at Arndt Family Chiropractic.

— **Medicare Patient**

We are on assignment with Medicare, therefore, payment will be directly reimbursed to our office based upon Medicare Chiropractic coverage. According to Medicare policy, Chiropractic coverage varies upon each additional patient's condition/diagnosis, therefore, upon termination of Medicare Chiropractic coverage, the Patient is responsible for the deductible, co-pay and office visits at that time.

— **Medicaid Patient**

If you are a Medicaid patient, and you have provided our office with a valid Medicaid card, we will bill Medicaid for you. If you don't have a valid Medicaid card, your account will be treated as a self-pay account and payment will be expected from you.

— **Commercial Insurance**

If you have supplied this office with complete insurance information at the time of registration, our office will submit your bill directly to your insurance company. Payment will be expected with 60 days of billing. If payment is not received 60 days, or your insurance company(ies) denies your claim, or the balance due is owing after your insurance company(ies) have paid, your account will be re-classified as a self-pay account, and we will bill you directly.

— **Worker's Compensation**

If this is a Worker's Compensation claim, and you have a valid claim number, this office will bill the account for you. If you don't have a claim number, it will be your responsibility to complete the necessary forms to obtain a claim number. We will assist you with the necessary forms.

— **Self-Pay**

If you have no insurance coverage, and you are ineligible for any government programs such Medicare, Medicaid, etc., you will be responsible for payment of services provided at Arndt Family Chiropractic. Payment is due at the time of services.





# **ARNDT FAMILY CHIROPRACTIC**

## **CONSENT FOR PURPOSE OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS**

I, \_\_\_\_\_, hereby give consent to Arndt Family Chiropractic (the "Practice") to use and disclose my Protected Health Information for the purpose of providing treatment to me, for the purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purpose. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conducted upon my consent as evidence my signature on this document. For purposes of this Consent, "Protected Healthcare Information" means any information, including my demographic information, created or received by the Practice that relates to my past, present or future physical or mental health condition; the provision of health care to me; or the past, present or future payment for the provision of health care services to me, and that either identifies me or from which this is a reasonable basis to believe the information can be used to identify me.

I understand that I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purpose of treatment, payment or healthcare operation of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

### **Release of Information**

- I hereby authorize Arndt Family Chiropractic to release any formation needed for completion of their claims for payment, for continuity of care or for Worker's Compensation claims. This includes, but is not limited to, my insurance company, my employer, any physician, hospital, social agency, welfare agency or governmental agency. I permit release of information concerning dates of chiropractic care, condition, diagnosis, procedures or treatments.
- Arndt Family chiropractic is authorized to release my medical records and/medical information to other physicians who will assist and/or will provide medical care to me, but who are not my primary treating physicians.
- I authorize Arndt Family Chiropractic to utilize my social security number when required for purpose of releasing information.
- I understand that if the authorized recipient is not a provider, health plan or clearing house required to comply with the federal standards, the information disclosed pursuant to this authorization may no longer be protected by the federal privacy standard and my health information may be re-disclosed by the recipient without obtaining any further authorization.

### **Notice of Privacy Practices**

I acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Arndt Family Chiropractic, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Personal Representative

\_\_\_\_\_  
Witness



# ARNDT FAMILY CHIROPRACTIC

## ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR PRIVATE AND GROUP HEALTH INSURANCE

RE: \_\_\_\_\_  
 Patient: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Claim/Group # \_\_\_\_\_ SSN \_\_\_\_\_

I hereby instruct and direct \_\_\_\_\_ (insurance company) to pay by check made out and mailed directly to:

Tricia L. Arndt, D.C.  
 7130 Muirfield Drive  
 Dublin, OH 43017

**OR**

If my current policy prohibits direct payment to said Doctor, then I hereby also instruct and direct \_\_\_\_\_ (insurance company) to make the check to me and mail it as follows:

Tricia L. Arndt, D.C.  
 7130 Muirfield Drive  
 Dublin, OH 43017

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment towards the total charges for professional services rendered. *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 have agreed to pay, in a current manner, any balance of said professional service charge over and above this insurance payment.

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

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Dated at Arndt Family Chiropractic, this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
 Signature of Policyholder

\_\_\_\_\_  
 Witness

\_\_\_\_\_  
 Signature of Claimant, of other than Policyholder