Genesis Chiropractic Center
59 East Mill Rd, Suite 3-102
Long Valley, N.J. 07853

INSURANCE INFORMATION

Patient Last Name _____ First Name _____ Middle _____

INSURANCE We need a copy of your card(s) for our records.

Insurance Company _____ Phone # ( ) _____
Insured's Name _____ ID/Policy # _____

Insurance Company _____ Phone # ( ) _____
Insured's Name _____ ID/Policy # _____

Insurance Company _____ Phone # ( ) _____
Insured's Name _____ ID/Policy # _____

RESPONSIBLE PARTY Complete this section if you are not the patient but are responsible for the bill.

Responsible Party _____
Relationship to Patient _____ SS# _____
Home Address _____ Apt# _____
City _____ State _____ Zip _____
Home Phone # _____ Work Phone # _____
Employer Name _____ Occupation _____

MY AUTHORIZATION

I authorize the **release** of any medical or other information necessary to process my claims. I also **request** payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

x _____ _____
Signature of patient or person acting on patient's behalf Date

MY FINANCIAL RESPONSIBILITY

I certify that the above information is correct. I understand that I am personally **financially responsible** for all services not paid for by my insurance. I am also responsible for any annual deductibles applicable, copayments, or non-covered services as may be required by my insurance plan.

x _____ _____
Signature of patient or person acting on patient's behalf Date

My Privacy;

I have received a copy of the Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health Information. I understand that this information can and will be used to: conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment; Obtain payment from third party payors; Conduct normal healthcare operations such as quality assessments and accreditation.

Patient Signature_____ Print Patient name_____Date_____