PRACTICE MEMBER INSURANCE INFORMATION: (MUST BE COMPLETED BEFORE SERVICES WILL BE RENDERED)

Patient Name: (First, Middle, Last)_____

Social Security Number _____-_____- _____

Contact in case of emergency: _____ Number: _____-_____-_____

Name of **Primary** Insurance Carrier: _____

Name of Insured: _____ Insured DOB: _____/_____/_____

Name of Policy Holder (if different than above) _____

Policy Holder DOB: _____/_____/_____

Name of **Secondary** Insurance Carrier: _____

Insurance policies and Fee schedule:

- Consultation- includes practice member history. This service is complementary.
- Physical Examination (new or established practice member)- includes postural analysis, range of motion assessment, static palpation, and motion palpation ($50-$100)
- Radiologic Examination- specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after a period of care ($40 per view set, or $160 total).
- Chiropractic adjustments: The actual realignment of the vertebral component. Often a sound will be heard, but if there is no auditory component, it does not mean that the adjustment did not take place. ($30-$40).

I authorize and request payment of insurance benefits directly to Shannon Bielski, DC and Hometown Chiropractic Spring Arbor PLLC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. Is it customary to pay for services when rendered unless other arrangements have be made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Signed: _____ Date: ____/ _____/_____