Patient Financial Responsibility Form

move chiropractic

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Insurance Information

☐ N/A ☐ I understand my insurance plan benefits ☐ I would like someone to call on my insurance plan benefits ☐ This condition is related to a work or auto accident *(Skip to work comp/auto accident)*

Primary Insurance

Company _____ Address _____

Subscriber # _____ Group # _____ Provider Phone # _____
Located on the back of the card

Insured Name _____ DOB ___/___/___ Relation _____

Secondary Insurance

Company _____ Address _____

Subscriber # _____ Group # _____ Provider Phone # _____
Located on the back of the card

Insured Name _____ DOB ___/___/___ Relation _____

Workers Comp/Auto Accident

Injury Date ___/___/___ Injury State _____ Claim # _____

Auto Insurance Company _____ Contact # _____

Person Responsible for Account

Last Name _____ First Name _____ MI _____ Relation _____

Street Address _____ Apt Number _____

City _____ State _____ Zip Code _____ Phone _____

DOB ___/___/___ SSN ___-___-___ Drivers License # _____ State Issued _____

Payment Method ☐ Cash ☐ Check ☐ Credit/Debit Card *(Fill out credit card payment form)*

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Move Chiropractic will prepare any necessary reports and forms to assist in making collections from the insurance company. I hereby grant Move Chiropractic permission to release the required information to receive reimbursement from my insurance carrier. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Patient Signature _____ Date ___/___/___

P: 701-799-4362
E: dramy@movechirond.com

4500 36th Ave S, STE 100
Fargo, ND 58104

movechirond.com

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Credit Card Payment Consent Form

First Name _____ Last Name _____ MI _____

Name on card if different _____

I authorize Dr. Amy Kempfer and the staff at Move Chiropractic to charge my credit card for professional services and products as follows.

Please read and initial:

_____ All dates of services beginning ____/____/____

_____ Recuring charge for dates of service at $ _____ per visit.

_____ All future appointments after ____/____/____

_____ I do not wish to have a card on file

Type of card ☐ mastercard ☐ VISA Expiration Date ____/____

Card # ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ 3 digit security code on back of card ☐☐☐

I hereby authorize collection of payment for all charges as indicated above. Charges may not exceed the amount listed above. I understand that this is only for up to this amount during the time period referenced above. If additional charges are going to be authorized a new form will need to be completed. I certify that I am the authorized holder and signer of the credit card listed above. I certify that all information above is complete and accurate.

Cardholder's Signature _____ Date ____/____/____

Statements/Receipts

☐ I would like my statements emailed / mailed to me

☐ I would like my statements emailed / mailed to me

Email _____

Street Address _____ Apt # _____

City _____ State _____ Zip Code _____

You agree, in order for us to service your account or to collect monies you may owe, Move Chiropractic and/or our agents may contact you by the email address or mailing address listed above when providing statements or receipts. I have read this disclosure and agree that Move Chiropractic & Acupuncture, its employees and/or agents may contact me as described above.

Patient Signature _____ Date ____/____/____

Office use only

Authorized Signature _____ Date ____/____/____

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Submit

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