BODY IN BALANCE

CHIROPRACTIC & ACUPUNCTURE

DR. AMY KEMPFER

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PATIENT FINANCIAL RESPONSIBILITY FORM

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 _____ **D.O.B** __/__/__ **RELATION** _____

SECONDARY INSURANCE

COMPANY _____ **ADDRESS** _____

SUBSCRIBER # _____ **GROUP #** _____ **PROVIDER PHONE #** _____
LOCATED ON THE BACK OF THE CARD

INSURED NAME _____ **D.O.B** __/__/__ **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** _____

D.O.B __/__/__ **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 Body in Balance Chiropractic will prepare any necessary reports and forms to assist in making collections from the insurance company. I hereby grant Body in Balance 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** __/__/__

CREDIT CARD PAYMENT CONSENT FORM

FIRST NAME _____ **LAST NAME** _____ **MI** ____

NAME ON CARD IF DIFFERENT _____

I AUTHORIZE DR. AMY KEMPFER AND THE STAFF AT BODY IN BALANCE CHIROPRACTIC TO CHARGE MY CREDIT CARD FOR PROFESSONAL SERVICES AND PRODUCTS AS FOLLOWS:

PLEASE READ AND INITIAL:

_____ **ALL DATES OF SERVICE BEGINNING** ___/___/___

_____ **RECURRING 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 RECEIPTS 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, Body in Balance 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 Body in Balance Chiropractic & Acupuncture, its employees and/or agents may contact me as described above.

PATIENT SIGNATURE _____ **DATE** ___/___/___

OFFICE USE ONLY

AUTHORIZED SIGNATURE _____ **DATE** ___/___/___