Insurance Information.

Patient's Name _____ DOB _____ SS#_____

Insurance Company _____ Are you responsible for this account? ❑ YES ❑ NO

Subscriber's Name _____ DOB _____ SS#_____

Relationship to Patient (*if not self*) _____

Is patient covered by additional insurance? ❑ YES ❑NO Secondary Insurance Co _____

Assigment & Release.

I agree to treatment by my doctor and such person's of the doctor's choosing, which may include, interns, preceptors, Chiropractic Assistants, ect, and hereby provide my consent for treatment. I, undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Dr. Shane Kurth(Chiropractor) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations. You have the right to ask us to restrict the uses or disclosures made for the purpose s of treatment, payment, or health care operations. Please refer to our Notice of Privacy Practice s for further information.

_____ _____

Responsible Party Signature **Date**

FEMALE PATIENTS ONLY: To the best of my knowledge, I believe I am not pregnant at the time X-Rays are taken at Apex Chiropractic.

SIGNATURE_____ DATE_____