INSURANCE INFORMATION

PATIENT'S NAME: _____
PHONE: (HOME) _____ **(WORK)** _____**(CELL)**_____
ADDRESS: _____
PATIENT'S DATE OF BIRTH: ___/___/___ **E-MAIL** _____

INSURED'S NAME (IF DIFFERENT FROM PATIENT): _____
ADDRESS: _____
INSURED'S DATE OF BIRTH: ___/___/___

INSURANCE COMPANY _____
ID# _____ GROUP# _____

DO YOU HAVE **SECONDARY COVERAGE?** IF SO, PLEASE PROVIDE:

INSURED'S NAME: _____
INSURED'S DATE OF BIRTH: ___/___/___

INSURANCE COMPANY _____
ID# _____ GROUP# _____

I UNDERSTAND AND AGREE THAT THE HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE COMPANY AND MYSELF. FURTHERMORE, I UNDERSTAND THAT CAUSEWAY CHIROPRACTIC WILL PREPARE ANY NECESSARY FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY AND THAT THE AMOUINT AUTHORIZED TO BE PAID DIRECTLY TO CAUSEWAY CHIROPRACTIC WILL BE CREDITED TO MY ACCOUNT. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ME ARE CHARGED DIRECTLY TO ME AND I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED ME WILL BE IMMEDIATELY DUE AND PAYABLE.

AUTHORIZATION TO PAY PHYSICIAN:
I HEREBY AUTHORIZE MY INSURANCE COMPANY TO PAY PROCEEDS OF ANY BENEFITS DUE TO ME BY CHECK AND MAIL TO:

Dr. Christopher J. Bott
Causeway Chiropractic
382 West 9th Street, Suite 8
Ship Bottom, New Jersey 08008

IF IT IS THE CASE THAT I HAVE NO INSURANCE COVERAGE FOR CHIROPRACTIC CARE, THEN I MYSELF WILL BE RESPONSIBLE FOR AND ALL CHARGES.

ALL PATIENTS PLEASE SIGN BELOW:

PATIENTS'S SIGNATURE
_____ DATE _____
INSURED'S OR GUARDIAN'S
SIGNATURE _____DATE_____