# PATIENT INFORMATION PIP

5290 Seminole Blvd. Suite A St. Petersburg, Fl. 33708

FLORIDA CHIROPRACTIC CLINICS

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Todays Date

Name SS No

Address Apt No

City St Zip

Home Phone No Cell No Work No

Emergency Contact? No

May We Send You Health Information Via Email? YES NO

Email Address

Employer

Occupation

Duties/daily Activities @ Work

Best Way To Contact You? Home Work Cell

Sex M F Marital Status S M D W

Age Date Of Birth

Reason For Coming In Today?

Date Of Injury?

Medical Physician's Name?

Last Visit

Are You Currently Taking Any Medications ?

Name Of Drug Amount

Amount

Amount

Any Allergies To Medications?

Possibly Pregnant? YES NO Due Date

Insurance Company:  Ph. No:

Address:

City: State: Zip:

Was This Accident Reported To Your Insurance Company? YES NO

If, No, Please Do This Today

Claim No: Policy No:

Adjuster's Name: Phone No: Ext.

Insured: Self Spouse Child Other:

Insured's Name:

If Insured Is Other Than Self, Please Complete:

Insured Address:

Phone No: Date Of Birth:

SSAN If Available:

Secondary Insurance Health Company:

Address:

City: State: Zip:

Phone No:

Claim No: Policy No: Group No:

Insured's Name:

Have You Signed With An Attorney: YES NO

If So, Whom:

Address:

City: State: Zip:

Phone No: Fax No:

# GENERAL SYMPTOM SURVEY

5290 Seminole Blvd. Suite A St. Petersburg, Fl. 33708

FLORIDA CHIROPRACTIC CLINICS

Name: Date:

## HEADACHES:

MILD MODERATE SEVERE 1 2 3 4 5 6 7 8 9 10 ( 10 = SEVERE )

**DESCRIPTION OF PAIN**: SHARP DULL THROB ACHE PRESSURE

**LOCATION**: FRONT RT. SIDE LT. SIDE BACK TOP BEHIND EYES

**DURATION**: CONSTANT OFF AND ON HOW OFTEN? TIMES PER DAY / WEEK

## NECK:

MILD MODERATE SEVERE 1 2 3 4 5 6 7 8 9 10 ( 10 = SEVERE )

**DESCRIPTION OF PAIN**: STIFF/TIGHT ACHE/SORENESS SHARP BURN THROB TINGLING DULL

**LOCATION**: FRONT RT. SIDE LT. SIDE BOTH

**DURATION**: CONSTANT OFF AND ON

**PAIN / TINGLING / NUMBNESS**: RT SHOULDER RT FOREARM RT HAND FINGERS LT SHOULDER LT FOREARM LT HAND FINGERS

## MID BACK:

MILD MODERATE SEVERE 1 2 3 4 5 6 7 8 9 10 ( 10 = SEVERE )

**DESCRIPTION OF PAIN**: STIFF/TIGHT ACHE/SORENESS SHARP BURN THROB TINGLING DULL

**LOCATION**: RT. SIDE LT. SIDE BOTH **DURATION**: CONSTANT OFF AND ON

## LOW BACK:

MILD MODERATE SEVERE 1 2 3 4 5 6 7 8 9 10 ( 10 = SEVERE )

**DESCRIPTION OF PAIN**: STIFF/TIGHT ACHE/SORENESS SHARP BURN THROB TINGLING DULL

**LOCATION**: RT. SIDE LT. SIDE BOTH **DURATION**: CONSTANT OFF AND ON

**PAIN / TINGLING / NUMBNESS**: RT THIGH RT KNEE RT CALF RT FOOT TOES RT THIGH RT KNEE RT CALF RT FOOT TOES

## HIPS:

MILD MODERATE SEVERE 1 2 3 4 5 6 7 8 9 10 ( 10 = SEVERE )

**DESCRIPTION OF PAIN**: STIFF/TIGHT ACHE/SORENESS SHARP BURN THROB TINGLING DULL

**LOCATION**: RT. SIDE LT. SIDE BOTH **DURATION**: CONSTANT OFF AND ON

## KNEES:

MILD MODERATE SEVERE 1 2 3 4 5 6 7 8 9 10 ( 10 = SEVERE )

**DESCRIPTION OF PAIN**: STIFF/TIGHT ACHE/SORENESS SHARP BURN THROB TINGLING DULL

**LOCATION**: RT. SIDE LT. SIDE BOTH **DURATION**: CONSTANT OFF AND ON

## JAW:

**DESCRIPTION OF PAIN**: STIFF/TIGHT ACHE/SORENESS SHARP POPPING/CLICKING RT. SIDE LT. SIDE BOTH

NERVOUSNESS IRRITABLE FATIGUE DEPRESSION SLEEP LOSS INCREASED STRESS DIZZINESS FAINTING BLURRED VISION
DOUBLE VISION LIGHT SENSITIVITY LOSS OF BALANCE HEARING LOSS RINGING IN EARS NERVOUS STOMACH
NAUSEA SHORTNESS OF BREATH INDIGESTION / HEARTBURN CONSTIPATION DIARRHEA ANXIETY

# INFORMED CONSENT FOR CHIROPRACTIC CARE

**(PATIENT AND DOCTOR AGREEMENT)**

5290 Seminole Blvd. Suite A St. Petersburg, Fl. 33708

FLORIDA CHIROPRACTIC CLINICS

When a patient seeks chiropractic health care and we accept a patient for care, it is essential that both the patient and doctor to be working toward the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risk, and alternatives. Our office's policy is as follows: "Your body, Your, Health, Your Choice." We will recommend what we feel is the best health care advice for you; however, it is your choice to do what you want with that advice whether it be to utilize our recommendations or to seek other means of health care for your condition.

CHIROPRACTIC has only one goal, the detection and correction of the VERTEBRAL SUBLUXATION. Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of HEALTH.
HEALTH: A state of optimal physical, mental, and social well-being, not merely the absence of disease, signs or symptoms.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Vertebral Subluxations are corrected and/or reduced by an adjustment. An ADJUSTMENT is the specific application of forces via hand or instrument to facilitate the body's correction of the vertebral subluxation. Our method of correction in this office is by specific adjustments utilizing the hands or an instrument as well. In addition, ancillary procedures such as physiotherapy and /or rehabilitative procedures may be included or recommended.
We do not offer to TREAT ANY DISEASES! We detect and correct vertebral subluxations as well as identify stresses the body may have on it that may limit its ability to function. We may recommend additional ancillary procedures that may benefit the reduction of these stresses however we DO NOT AND WILL NOT TREAT INDIVIDUAL DISEASES, NOR MAKE THAT CLAIM. We may have patients with certain diseases; however we treat the patient by removing and/or reducing the vertebral subluxation and their stress, not the DISEASE. If during the course of our care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider that may specialize in that area.

Like most health care procedures, the chiropractic adjustment carries with it some risks. The POSSIBILE RISKS may include temporary soreness or increased symptoms of pain. (It is not uncommon for patients to experience temporary soreness or increased symptoms of pain after the first few treatments). Dizziness, nausea, flushing, as well as fractures, may occur (These symptoms are relatively rare). When a patient has underlying conditions that may weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. Treatment plans will be modified accordingly. Spinal conditions like a disc herniation or bulge can potentially worsen with chiropractic care, however we take a very gentle approach to such conditions and oftentimes treatment is extremely effective. A certain extremely rare

type of stroke/cerebro-vascular injury can be associated with chiropractic care. This occurrence has been estimated at one in one million to one in twenty million but often even further reduced by cardiovascular screening procedures by our office. Other risks associated with chiropractic treatment include rare burns from physiotherapy devices.

I understand that the practice of chiropractic, like the practice of all healing arts and medicine, is not an exact science, and I acknowledge that no guarantees can be given as to the results or outcome of my care.
OTHER TREATMENT OPTIONS which could be considered may include the following:

Over-the counter analgesics:  The risks of these medications include irritation of the stomach, liver, kidneys, and other side effects in a significant number of cases.

Medical Care:  typically anti-inflammatory drugs, tranquilizers, and analgesics.  Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
Hospitalization:  in conjunction with medical care adds risk of exposure to virulent communicable diseases.
Surgery:  in conjunction with medical care adds the risk of adverse reactions to anesthesia, as well as an extended convalescent period.

RISKS OF REMAINING UNTREATED:  Delay of treatment allows a formation of adhesions, scar tissue, and other degenerative changes to take place.  These changes can further reduce skeletal mobility and induce chronic pain cycles.  It is quite possible that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read or had read to me this informed consent document.  I have discussed, or been given the opportunity to discuss, any questions concerning my treatment.  My chiropractor explained and answered any questions/concerns to my satisfaction prior to my signing this informed consent document.  I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

Printed Name _____ Signature _____ Date

# PAYMENT INSURANCE INFORMATION

5290 Seminole Blvd. Suite A St. Petersburg, Fl. 33708

FLORIDA CHIROPRACTIC CLINICS

## Payment/Insurance Information

Our office policy states that payment is due when Services are rendered!

As a courtesy, we will file your auto and medicare insurance claims for you.

We are no longer in network with any health insurance. We can print you a receipt with the appropriate information for you to submit to your insurance company for possible reinbursement.

( ) Cash/check/credit card: payment is due when services are rendered.

( ) Automobile insurance: we must have a copy of your insurance card, verification of insurance and a copy of the accident report if available. Any charges not covered by the insurance company will be directly billed to you for payment.

( ) Medicare: we must have a copy of your medicare card.

Insured name:

Insured D.O.B.:

Relationship to insured:

Insurance company name:

I have read the above and checked one method of payment. I have agreed that the balance is my responsibility and will pay any balance that has gone unpaid over 60 days. If balance owed after stated period has not been met, i understand that i will be responsible for all fees incurred (attorney, collection agencies, court cost, interest and any other fees needed to collect the balance) such that the balance owed to this office is paid in full.

Please print name: Date:

Please sign to acknowledge form: _____

# RECEIPT OF PRIVACY PRACTICES

5290 Seminole Blvd. Suite A St. Petersburg, Fl. 33708

FLORIDA CHIROPRACTIC CLINICS

## ACKNOWLEDGEMENT OF RECEIPT

## OF

## NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of, or had the opportunity to read, the NOTICE OF PRIVACY PRACTICES ( located in the waiting room ).

I have read them or declined the opportunity to read them and understand the NOTICE OF PRIVACY PRACTICES.

I understand this form will be placed in my patient chart and maintained for a period of six years.

DATE:

PATIENTS NAME (PLEASE PRINT)

_____

SIGNATURE

PLEASE LIST BELOW THE NAME AND RELATIONSHIP OF PEOPLE TO WHOM YOU AUTHORIZE RELEASE OF PHI.

THIS FORM WILL BE MAINTAINED IN THE PATIENT'S CHART FOR A PERIOD OF SIX YEARS.

# INSURANCE POLICIES & GUIDELINES

5290 Seminole Blvd. Suite A St. Petersburg, Fl. 33708

FLORIDA CHIROPRACTIC CLINICS

The purpose of this letter is to let you know how our facility works in the handling of your insurance claims. We do this to eliminate any questions, and to inform you of all our policies in advance to better enable us to serve you in your health care needs effectively. In this way, policies can be followed as intended.

We itemize all of our procedures. The reason for this is to let the insurance company personnel know exactly what services were performed on you on each of your visits, what was not performed on you each of your visits, and why. In reporting to your insurance company, we are responsible to them on your behalf to accurately inform them as to your condition, status, complications, exacerbations, unusual circumstances affecting your health and care that would affect your recovery and journey to optimal health. We are responsible for letting them know how long we anticipate your care will be, to what frequency we need to see you, and your progress. All of this involved a tremendous amount of staff and professional time and expense. However, we do this as a courtesy service for you as it lessens the burden of you having to communicate with the insurance company and not having the proper knowledge or information to provide them. It also lessens the responsibility and threat regarding when insurance companies will no longer cover your care. This makes a far easier process for you and for us. All we ask is your cooperation. Our usual procedures and their costs are listed separately, and a copy of these can be provided when asked.

Because we itemize and document every procedure in accordance with the insurance protocol, rather than just describe what is being done as an “office visit”, the charges per visit may vary in costs, especially when multiple services are rendered. For various reasons, we know that there are a lot of charges that may not be paid, such as maximum dollar amounts, limits per visits, procedures that the policy does not cover or deem medically necessary, etc. We expect to receive denials on claims, as it is the nature of the insurance industry. However, we are still going to bill for everything we do, whether we get reimbursed for our services or not, so that we can adequately document and communicate our visit procedures with the insurance companies.

Different insurance companies cover different procedures and in different amounts. Some companies pay 100% and some pay 60%. Some patients under their policy will have $0 deductible while others may have a $1000 deductible. Such things are based upon your individual policy. We can only make you aware of this as you may see multiple patients paying different amounts for their care.

As a courtesy to you, we will verify your insurance benefits prior to performing any procedures on you. WE CAN NOT GUARANTEE the information your insurance company provides us is accurate information, as numerous times, the information they provide us on verification of your benefits is not the same as what they provide to us when paying the claim. You, as the patient, are still responsible for the payment of services for any unpaid balance if the insurance company fails to provide us with proper valid information and there is a discrepancy between what was verified and what was acknowledged and paid/unpaid.

If you have a special financial situation that makes it difficult or impossible for you to meet your financial requirement of paying any unpaid balance remaining owed, please consult the DOCTOR or OFFICE MANAGER so we may discuss this matter with you. Special considerations or small weekly or monthly payments can sometimes be arranged to fit your needs and thus allow you to get the proper care you need at a fee you can afford.

Printed Name _____ Signature _____ Date

# POWER OF ATTORNEY AND MEDICAL RELEASE

5290 Seminole Blvd. Suite A St. Petersburg, Fl. 33708

FLORIDA CHIROPRACTIC CLINICS

## POWER OF ATTORNEY AND MEDICAL RELEASE

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PIECE OF PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS.AUTHORIZATION TO PAY.

Know by all those present that: The undersigned has made, constituted, and appointed, and by those present does hereby make, constitute and appoint **FLORIDA CHIROPRACTIC CLINICS, INC.**, and any of its duty authorized agents and employees as and to the undersigned's true and lawful attorney for and in the undersigned's name, place, and stead to endorse any and all checks, drafts, money orders which are made payable to the undersigned alone or to the undersigned and the said **FLORIDA CHIROPRACTIC CLINICS, INC.** which checks, drafts, money orders are made payable for services which have been made by **FLORIDA CHIROPRACTIC CLINICS, INC.** at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft, money order.

Furthermore, the undersigned allows **FLORIDA CHIROPRACTIC CLINICS, INC.**, or any of its agents to sign any paper that will be necessary to enhance, expedite, and/or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements.

The undersigned by those present, does give and grant **FLORIDA CHIROPRACTIC CLINICS, INC.** as attorney, full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are concerned as well as any other document.

MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, and supplies pertaining to me to release true copies of same to **FLORIDA CHIROPRACTIC CLINICS, INC**. or any insurer providing coverage to me in connection with the processing of any claim for benefits made or by the assignee herein. A photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which said attorney shall do or cause to be done by virtue of these presents.

ASSIGNMENT OF BENEFITS

I, _____ Hereby authorize _____

(Name of Insured/Patient) (Name of Insurance Carrier)

To make medical payments otherwise payable to me for services rendered by FLORIDA CHIROPRACTIC CLINICS, INC., but not to exceed the charges of those services, payable and mailed directly to:

FLORIDA CHIROPRACTIC CLINICS, INC.

5290 Seminole Blvd. Suite A
St. Petersburg, FL 33708

Furthermore, I hereby **IRREVOCABLY ASSIGN** to **FLORIDA CHIROPRACTIC CLINICS, INC.**, the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by **FLORIDA CHIROPRACTIC CLINICS, INC**.

**IN WITNESS WHEREOF** the undersigned have hereunto set their hands, this _____day of _____, 20___.

_____ _____

PATIENT'S SIGNATURE PATIENT'S NAME (Please Print)

# AUTHORIZATION FOR MEDICAL INFORMATION

5290 Seminole Blvd. Suite A St. Petersburg, Fl. 33708

FLORIDA CHIROPRACTIC CLINICS

This authorization of photocopy hereof will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including history obtained, x-rays and physical findings, diagnosis, and prognosis. You are authorized to provide information in accordance with Florida's "No Fault" Auto Insurance Law.

_____

Signature Date

## PREGNANCY RELEASE FOR X-RAYS

I, do hereby state to the best of my knowledge that I am not pregnant and give full permission to FLORIDA CHIROPRACTIC CLINICS, INC. their associates, or assistants to x-ray me. My last cycle began on

.

_____

Signature Date

# FEE GUARANTEE AGREEMENT

5290 Seminole Blvd. Suite A St. Petersburg, Fl. 33708

FLORIDA CHIROPRACTIC CLINICS

NAME:

ACCIDENT DATE:

I, the above noted Patient, do hereby authorize and direct my present and any future attorney to honor this fee guarantee agreement. This agreement is made in favor of the above named Medical Provider and shall be termed a "Letter of Protection." The Letter of Protection shall serve to place a continuing lien on any proceeds I recover in any legal action related to the above noted accident date.

**Consideration**. In consideration of the medical treatment provided and time provided to pay for said medical treatment, I hereby grant a direct lien on any and all funds I may recover in any legal action related to the above accident date.

**Protection of Outstanding Charges**. The above named Patient hereby agrees that if s/he recovers any money from any person or entity in connection with any legal action related to the above noted accident date, the Patient shall withhold from those funds, sufficient money pay the full outstanding balance of any bill(s) owed to the above named Medical Provider for treatment or any work completed in relation to the above noted accident date. Those funds shall be deducted prior to any other party removing funds for any reason, including but not limited to attorney's fees, costs, other court fees, or any other bill or lien whatsoever. Patient hereby directs their present and/or future attorney to pay said outstanding medical bill in connection with the above noted treatment. This agreement shall obligate each attorney who represents the above named patient in any way and recovers any funds related to the above noted accident date and creates a constructive trust with said attorney. Further, this agreement shall extend pay any outstanding balance for any copies, costs or reports the above named Medical Provider endures in relation to any legal issue for the above accident date. The Patient hereby agrees to waive any rights they have, under contract, law or equity, to have the Medical Provider bill a third party entity, including but not limited to any contracted payer, health insurer or government payer and further desires to pay for the medical treatments through the legal action's proceeds.

**Patient Responsibility**. It is the Patient's responsibility to advise each and every attorney of the existence of this agreement. Further the Patient must advise the above named Medical Provider at reasonable intervals the status of the legal case. It is also the Patient's responsibility to advise the Medical Provider within 5 days of legal matter collecting any funds and to request a bill for any and all outstanding charges. The Patient hereby directs their present attorney and any future attorney to advise the Medical Provider, as soon as possible, about any funds related to the accident case becoming available to the above named Patient. Further, if the legal action fails

to fully pay the Medical Provider's outstanding balance(s) then the remaining amounts are to be paid by the Patient. The Medical Provider may, at his/her discretion at any time, bill any third party payer or government payer.

**Disputes**. If there is a dispute over the Medical Provider's outstanding charges the Patient agrees to submit the full amount due to the Medical Provider and agrees to bring an action in Florida State Court for recovery of the disputed difference. If the Patient fails to pay the Medical Provider's full outstanding balance, and thereafter Medical Provider brings suit to collect said sums, Medical Provider shall then have the right to recover attorney fees and costs for bringing an action to enforce this particular provision.

**Approval Required**. This agreement becomes effective when the Patient signs the agreement below. This agreement does not need the approval of any present or future attorney for the Patient.

The parties agree that no party shall be considered the drafting party to this contract.

DATED:

PATIENT SIGNATURE _____

# AUTOMOBILE ACCIDENT QUESTIONNAIRE

5290 Seminole Blvd. Suite A St. Petersburg, Fl. 33708

FLORIDA CHIROPRACTIC CLINICS

What was the DATE and TIME of the accident?

Which direction were you heading? North South East West

Which direction was the other Person(s) heading? North South East West

On which street or Intersection?

Were the Police notified? Yes No Who was cited?

Were you knocked unconscious? Yes No

Were you struck from: Behind Front Left Side Right Side

Were you the: Driver Front Passenger Back Seat/Driver's Side

Back Seat/Passenger Side Other:

Did you feel pain immediately after the accident? Yes No

If YES, please explain:

Were you wearing your Seatbelt? Yes No

Did the Airbag deploy? Yes No

Were you looking straight ahead at impact? Yes No

If NO, please explain:

Were you treated after the accident? Yes No Where?

If so, what treatment was given?

Was a Doctor consulted after the accident? Yes No

If so, who was the Doctor?

What Treatment was given?

When was the last time you received treatment for this accident?

Are you presently able to work? Yes No

NAME: Date:

Please explain in full detail how this accident happened:

Please list all of your complaints/injuries:

Have you ever had these complaints before? Yes No

If YES, please explain:

Is this your first accident? Yes No

If NO, please list dates:

#1. When?

#2. When?

#3. When?

#4. When?

Name: Date:

Please sign and date in boxes 12 and 13 only. No need to fill rest of form out.

# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, complete items 9, 9a, and 9d.

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| 24. A. DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | NPI | |
| 2 | | | | | | | | | | NPI | |
| 3 | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

**PLEASE PRINT OR TYPE**

APPROVED OMB-0938-1197 FORM 1500 (02-12)