A. Little Chiropractic Center

DR. ALICIA LITTLE

424 East Second Street

Defiance, OH 43512

419-782-2272

Insurance Information Form

Patient Name_____Date_____

Date of Birth_____

Responsible Party Please complete if you are not the patient but you are responsible for the bill.

Responsible Party_____

Relationship to patient_____

Address_____ Apt #_____

City_____ State_____ Zip Code_____

Home Phone_____ Work Phone_____

Employer Name_____ Occupation_____

Primary Insurance Information

Insurance Company Name_____

Policy Holder Name_____ Policy Holder DOB_____

Patient Relationship to Policy Holder_____

Policy ID#_____ Group #_____

Please flip over

Secondary Insurance Information

Insurance Company Name_____

Policy Holder Name_____ Policy Holder DOB_____

Patient Relationship to Policy Holder_____

Policy ID#_____ Group #_____

Authorization and Release

I authorize payment of insurance benefits directly to A. Little Chiropractic Center. I authorize the doctor to release all information needed to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of care, regardless of insurance coverage. I understand and agree to allow A. Little Chiropractic Center to use my Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care.

I understand that this is permanent authorization and can be ended at any time by submitting a request in writing.

Medicare Beneficiaries: I request that payment of authorized Medicare benefits be made to A. Little Chiropractic Center. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine benefits or benefits payable for related services.

X_____ _____

Signature of patient or person acting on patient's behalf Date