LECHMAIER FAMILY CHIROPRACTIC CENTER

1051 Town Center Drive
Orange City, FL 32763
Office: 386-775-8600 Fax: 386-775-3602

AUTOMOBILE ACCIDENT HISTORY FORM

Full Name ______________________________ Today's Date ______________

Address ______________________________ City ______________ State _____ Zip ________

Home Phone ______________ Work Phone ______________ Occupation ______________

Sex ☐ M ☐ F Marital Status ☐ S ☐ M ☐ D ☐ W Age ________ Birthday ____/____/____

Race ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Asian ☐ Other ______________ SS# ______________

Referred By: Attorney ______________________ Insurance ______________________

Doctor ______________________ Other ______________________

HISTORY OF ACCIDENT (check all that apply)

1. Date of Accident ______________ Time of Accident ______________ Date of Exam ______________
2. Description of Accident ____

____

____

____

3. Location of Accident Street ______________________ City ______________________ State ____
4. ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other ______________________
5. ☐ Traveling ☐ Stopped facing ☐ N ☐ S ☐ E ☐ W ☐ Unknown Direction
6. **YOUR** Vehicle Type: ☐ Compact ☐ Midsize ☐ Truck ☐ Sport Utility ☐ Van ☐ Semi-truck
7. **OTHER** Vehicle Type(s): ☐ Compact ☐ Midsize ☐ Truck ☐ Sport Utility ☐ Van ☐ Semi-truck
8. Who was issued the citation? ☐ Nobody, we exchanged insurance info ☐ I was / My party ☐ Other party
9. ☐ Stopped and rear-ended ☐ Moving and rear-ended ☐ Slowing down to make stop / turn and rear-ended

   ☐ Head-on collision – other vehicle traveling in opposite direction ☐ Side swiped RIGHT / LEFT ☐ Rolled over

   ☐ Another vehicle ran stop sign / red light ☐ Lost control of vehicle ☐ Spun around ☐ T-boned RIGHT / LEFT
10. If rear-ended, did the force of the impact cause your vehicle to collide with another vehicle? ☐ Yes ☐ No
11. Road conditions at the time of the accident: ☐ Wet ☐ Dry ☐ Icy ☐ Other ______________________
12. Approximate speed of **YOUR** vehicle: __________mph
13. Approximate speed of **OTHER** vehicle: __________mph
14. Were you wearing a seat belt? ☐ Yes ☐ No Were you aware of the impending collision? ☐ Yes ☐ No
15. How far is the top of the headrest or seatback from the top of your head? (measurement in inches)

   ☐ 0" ☐ 1" ☐ 2" ☐ 3" ☐ 4" ☐ 5" ☐ 6" ☐ Other __________ ☐ Above ☐ Below
16. Did you strike any objects in the car? ☐ Yes ☐ No
17. If yes, then what? ☐ Steering column ☐ Rearview mirror ☐ Seat broke ☐ Dashboard

   ☐ Door frame ☐ Headrest ☐ Jarred or thrown about ☐ Windshield

   ☐ Cannot remember details (dazed) ☐ Other ______________________
18. What portion of your body did you strike? ☐ Head ☐ Chest ☐ Face ☐ Arms ☐ Hands ☐ Legs ☐ Knees

   ☐ Shoulder ☐ Hip ☐ Other ______________________

19. As a result of the accident were you? ☐ not injured ☐ cut/bleeding ☐ bruised ☐ dizzy ☐ nauseas ☐ blurred vision ☐ unconscious ☐ ringing/buzz in ears ☐ partially paralyzed ☐ other ____________

20. If cut, bruised, and/or partially paralyzed please explain where ____________

21. If you experienced immediate pain, please indicate where:

☐	Headache	☐ Left	☐ Right	☐	Neck pain	☐ Left	☐ Right
☐	Upper-back pain	☐ Left	☐ Right	☐	Mid-back pain	☐ Left	☐ Right
☐	Chest pain	☐ Left	☐ Right	☐	Low-back pain	☐ Left	☐ Right
☐	Arm	☐ Left	☐ Right	☐	Elbow	☐ Left	☐ Right
☐	Knee	☐ Left	☐ Right	☐	Leg	☐ Left	☐ Right
☐	Other ____________						

22. After the accident, did you? ☐ go home ☐ go to work ☐ go about your business ☐ go to the hospital

HOSPITALIZATION

23. If taken to the hospital, how did you get there? ☐ Ambulance ☐ Driven by friend / relative ☐ Drove yourself ☐ Went later

24. If you went later, then when? ____________ Name of hospital ____________

25. Were you seen in the emergency room? ☐ Yes ☐ No

26. Were you admitted to the hospital? ☐ Yes ☐ No

27. If admitted, how long did you stay? ____________

28. Name of admitting or hospital physician? ____________

29. What was done in the emergency room or hospital? ☐ Examination ☐ Stitches ☐ X-rays ☐ Surgery ☐ Physical Therapy ☐ Casting ☐ Cervical collar ☐ Prescription(s) ____________ ☐ Other ____________

30. After being released, what did you do? ☐ Return home to bed ☐ Return to work ☐ Return to the emergency room ☐ Other ____________

31. When did you first consult a physician? ☐ Same day ☐ Following day ☐ Within a few days ☐ Did not consult one ☐ Other ____________

(If patient consulted this office, skip to PAST HISTORY)

32. Who did you consult? Dr. ____________ ☐ Family Physician ☐ Chiropractor ☐ Orthopedist ☐ Osteopath ☐ Neurologist ☐ Other ____________

33. What did the doctor do? ☐ Chiropractic manipulation ☐ Examination ☐ X-rays ☐ Injections ☐ Traction ☐ Physiotherapy ☐ Prescription(s) ____________ ☐ Other ____________

34. How long were you under this doctor's care? ____________

35. Are you still under this doctor's care? ☐ Yes ☐ No

36. Frequency or number of visits now? ____________

37. Did the doctor refer you to or have you been to any other physician? ☐ Yes ☐ No
    If yes, explain: ____________

38. Were you sent for an independent medical examination? ☐ Yes ☐ No
    If yes, to whom? ____________

39. Other pertinent information ____________

____

____

PAST HISTORY

40. Have you ever been in any previous accident of any kind? ☐ Yes ☐ No

    If yes, please give dates and details ______________________________

41. Were you rendered permanently impaired? ☐ Yes what % __________ ☐ No

42. Has any other physician prior to this accident ever treated you for neck or back problems? ☐ Yes ☐ No

    If yes, please explain ______________________________

43. Have you had any previous surgeries or any conditions that I should know about? ☐ Yes ☐ No

    If yes, please explain ______________________________

44. Were you symptom free and in good health before this accident? ☐ Yes ☐ No

    If no, please explain ______________________________

PRESENT COMPLAINTS

45. Please list your current problem areas (prioritize with worst being #1)

    1. ______________________________
    2. ______________________________
    3. ______________________________
    4. ______________________________
    5. ______________________________
    6. ______________________________
    7. ______________________________
    8. ______________________________

46. Have you lost any time from work since the accident? ☐ Yes ☐ No

47. If yes, how many days? __________ Are you still off work? ☐ Yes ☐ No

48. Date returned __________ Job description __________

49. In what way have your injuries affected your ability to work? ______________________________

50. Have your injuries affected your hobbies and/or recreational activities? ☐ Yes ☐ No

51. If yes, please explain. ______________________________

49. If you have an attorney representing you, please give name, address, and telephone number:

Name __________ Firm __________

Address __________ City __________

State ______ Zip __________ Phone __________

REVISED 02-02

LECHMAIER FAMILY CHIROPRACTIC CENTER

PAYMENT POLICIES

1. All first visit charges are payable when services are rendered.

2. At the completion of your first office visit you will be advised as to a time you may return for your second consultation when the doctor will inform you as to your examination results and whether or not your case has been accepted. You will then be advised concerning treatment options, financial arrangements, and insurance coverage as appropriate.

3. Method of payment you plan to use to take care of today's charges? [ ] Cash [ ] Check [ ] Visa/MasterCard

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Lechmaier Family Chiropractic Center will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Lechmaier Family Chiropractic Center will be credited to my account upon receipt. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this account. I authorize Lechmaier Family Chiropractic Center to obtain a credit report if deemed necessary.

Patient Name ______________________ Patient's Signature ______________________ Date ________

DIRECT PAYMENT AUTHORIZATION

I hereby instruct and direct payment to be made payable to and mailed directly to:

LECHMAIER FAMILY CHIROPRACTIC CENTER
852-35 SAXON BLVD.
ORANGE CITY, FLORIDA 32763
OFFICE: 386-775-3600 FAX: 386-775-3602

In consideration of the services rendered I authorize and direct the payment to the above named of any sum I now or hereafter owe out of the proceeds of any settlement of my case, and/or by any insurance company obligated to reimburse me for the charges for these services. The payment will not exceed my indebtedness to the above mentioned.

A photocopy of this authorization shall be considered as effective and valid as the original. I authorize the use of this form for all insurance claims from Lechmaier Family Chiropractic Center.

Patient Name ______________________ Patient's Signature ______________________ Date ________

X-RAY / MEDICAL RECORDS RELEASE

I authorize the release of any medical information necessary to physicians, employers and/or insurance companies which would expedite the process of my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

I authorize the taking of photographs and x-rays to be used for treatment purposes.

I authorize the performance of other diagnostic and therapeutic procedures for treatment purposes.

I have requested the release of records of (patient's name)______________________ which are a part of the records at (facility)______________________

I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by them, all insurance information, copies of records and reports, including copies of x-rays, and any other information they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future.

Patient Name ______________________ Patient's Signature ______________________ Date ________

Guardian Name ______________________ Guardian's Signature ______________________ Date ________

SEMI-OPEN ROOM ADJUSTING CONSENT FORM

I hereby give consent to have chiropractic adjustments performed in a semi-open room setting. I acknowledge that closed rooms are available to me at any given time, but my result in longer wait times. I understand that a semi-open room setting does not ensure complete privacy and will inform the staff if I need to discuss any confidential information in private.

Patient Name____________________ Patient's Signature____________________ Date__________

TERMS OF ACCEPTANCE AND CONSENT FOR CARE

THIS DOCUMENT CONSTITUTES INFORMED CONSENT FOR CHIROPRACTIC CARE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same goal.

Chiropractic has only one goal. It is important for each patient to understand this goal and the method that will be used to attain it. This will prevent confusion or disappointment.

"Vertebral Subluxations" are mechanical interferences, by the spinal bones, to the normal flow of mental impulses traveling over the nerve pathways. The goal of chiropractic is to locate, analyze and correct these vertebral subluxations.

The method of correction is by specific adjustments to the spine. These adjustments are intended to reduce vertebral subluxations, thereby allowing the innate healing abilities of the body to work at maximum efficiency.

With a proper nerve supply restored through chiropractic adjustments, the body can begin the process of repair leading to health. In some patients this happens quickly; in others, more slowly. In some patients the repair and maintenance is complete; in others, only partial.

We do not offer to diagnose or treat any disease or condition other the vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will so advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of the health care provider who specialized in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY GOAL IS TO ALLOW THE BODY TO DO ITS JOB. Our only method is the spinal adjustment of vertebral subluxations.

I, ____________________ (Print Name) have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on that basis ____________________ (Signature) __________ (Date)

Complete if Patient is a minor child.

____________________ (Print Child's Name)

I, ____________________ being the parent or legal guardian of the aforementioned child have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

____________________ (Signature) __________ (Date)

CONSENT TO CARE

A patient coming to the doctor gives him/ her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/ she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/ she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I have read and understand the foregoing.

_________________________________ _____________________

Patient's Signature Date

X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: ____________________________

☐ There is a possibility that I a may be pregnant at this time.

☐ Yes, I am definitely pregnant

☐ No, I am definitely not pregnant at this time

☐ I request that x-ray films not be taken because: ________________________

____

____

Date of last menstrual period: _______________

________________________ _________________

Patient's Signature Date

Lechmaier Family Chiropractic Center

"TOUCHING THE COMMUNITY, REACHING THE WORLD"
1051 Town Center Drive
Orange City, Fl 32763
Phone: (386)775-3600 Fax: (386)775-3602

Disclosure And Acknowledgement Form
In Compliance with Florida Statue 627.736

Today's Date: ___/___/___
Patients Name: ______________________________ Patient's date of birth___/___/___
Print
If patient is a minor, Guardian's name____________________________________

Date of initial treatment at Lechmaier Family Chiropractic___/___/___/

FOR ADULT PATIENTS:

I, ______________________, attest and affirm that I was not solicited by any person to seek any service from this medical provider.

I, ______________________, attest to the fact and confirm in writing that the services as stated and carried out by treating physician were actually performed on my person.

I, ______________________, attest to the fact and confirm in writing that services as stated and carried out by treating physician were explained to me in terms I understood.

I, ______________________, attest to the fact and confirm in writing that I have been informed by this clinic that should I find a billing error in Lechmaier Family Chiropractic's charges to my PIP carrier, and inform my PIP carrier of such error, that I may be entitled to a certain percentage of a reduction paid as a result of such findings.

Signature of Adult Patient: ______________________________Date:___/___/___

Signature of Treating Physician: ______________________________Date:___/___/___

Office of Insurance Regulation
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

____

____

2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable ***(Signature by his/ her own hand)***:

Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

OIR-B1-1571
Pub. 1/2004

Lechmaier Family Chiropractic Center
1051 Town Center Drive
Orange City, FL 32763

TO____

____

____

RE: HEALTH RECORDS AND PROVIDER'S LIEN

I do hereby authorize the above provider, Lechmaier Family Chiropractic Center, to furnish you, my attorney, with a full report of this examination, diagnosis, prognosis, etc.; of myself in regard to the injury in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to Lechmaier Family Chiropractic Center such sums as may be due and owing them for medical services rendered me both by reason of this injury and by reason of any other bills that are due their office and to withhold sums from and settlement, judgment or verdict as may be necessary to adequately protect said provider. I hereby further give a lien on my case to said company against any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries for which I have been treated or injuries in connection herewith.

I fully understand that I am directly and fully responsible to said provider for all medical bills submitted by them for services rendered me and that this agreement is made solely for said provider's additional protection and in consideration of their awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I forbid you, my attorney, from paying my provider any sums less than the full amounts owed to said provider, without its written consent.

Dated:________________ Patient's Signature:____

The undersigned being attorney of record for this above patient does hereby agree to observe all of the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said provider above named.

Dated:________________ Attorney's Signature:____

ACKNOWLEDGMENT OF LIABILITY
ASSIGNMENT OF BENEFITS

The undersigned patient and/or responsible party, hereby acknowledge personal responsibility and liability for all the medical services, which are provided by ______________________________. This personal obligation is not affected by any obligation of insurance companies to pay health care costs. If an insurance company pays the payments shall be credited to your account. If no insurance payment is received, you are completely responsible to pay for all medical treatments. In addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered, the undersigned hereby assigns to the physician or facility named above the following rights, power, and authority:

CONSENT FOR TREATMENT: The undersigned hereby consents to the provision of examination, fitness evaluations, treatments, therapies, medical and laboratory procedures, and drugs and supplies to the patient as ordered by the patient's health care provider ______________________________, their physicians, nurse practitioners, physical therapists, certified athletic trainers or staff, and acknowledges that no guarantee or assurance has been made to the results of such treatments, procedures or examinations.

RELEASED INFORMATION: You are authorized to release and to permit the examination or copying of any of my medical records, x-rays, laboratory reports, and the results of all tests of any type or character to such person(s) as the Physician and/or facility deems appropriate.

ASSIGNMENT OF RIGHTS: You are assigned to exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company or other person or entity to the extent of your bill for total services, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payments, and prosecute and receive penalties, interest, court costs or other legally compensable amounts owed by an insurance company or other person of entity. I, as the patient and/or responsible party, further agree to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request. The physician and/or facility is also assigned the exclusive, irrevocable right to request and receive from any insurance company or health care plan any and all information and documents pertaining to my policies including a copy of such policy and my information or supporting documentation concerning or touching upon the handling, calculation, processing, or payment of any claim.

DEMAND FOR PAYMENT: As to any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above you are hereby tendered the right to demand payment in full the bill for services rendered by the physician/facility named above following your receipt of such bill for services to the extent such bills are payable under the terms of my/our policy for benefits, less any amounts which I/we owe personally which are not payable under the terms of your policy.

THIRD PARTY LIABILITY: If patient(s) treatments for injuries are the result of the negligence of any third party, then patient(s) grant a secured interest (lien) against any recovery from such third party(s) to the extent of the bills for treatment in favor of the physician/facility named above.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above power of attorney to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and health care rendered by physician/facility. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above

In the event that any provision of this Agreement is determined to be invalid or unenforceable, all other provisions of this Agreement shall remain enforceable.

A PHOTOCOPY OF THIS INSTRUMENT SHALL SERVE AS ORIGINAL

Signature of patient and/or responsible party:

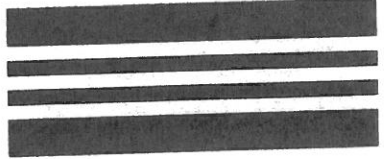
Sign Here ______________________________ Date: ____________________

Print Name Signature______________________________ Relationship to patient: ____________________

PATIENTS NAME: ______________________________ Date of Accident: ____________________

APPROVED OMB-0938-0008

PLEASE
DO NOT
STAPLE
IN THIS
AREA



CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) 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. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

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 ______

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ___ . ___
2. ___ . ___
3. ___ . ___
4. ___ . ___

22. MEDICAID 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 Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1											
2											
3											
4											
5											
6											

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. BALANCE DUE $

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. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500