PATIENT NAME (Last, First, Middle) _____

FINANCIAL: Cash / Insurance / Work Related / Medicare / Auto Accident / Attorney
DATE OF BIRTH: ____/____/_____ MARITAL STATUS: Single / Married / Divorced / Widow(er)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: ___ ___ ___ ___ ___

CELL PHONE: _____ ADD PHONE _____

SOCIAL SECURITY # ___ ___ ___ - ___ ___ - ___ ___ ___ ___ GENDER: Male / Female
EMAI: _____@_____
PATIENT'S EMPLOYER : _____
EMPLOYER'S ADDRESS: _____

NAME OF SPOUSE OR PARENT IF PATIENT IS A MINOR: _____
SPOUSE/PARENT EMPLOYER: _____
SPOUSE/PARENT SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___ PHONE #_____
SPOUSE/PARENT'S DATE OF BIRTH: _____/_____/_____

NAME OF INSURED: _____
INSURANCE COMPANY: _____ DATE OF BIRTH _____/_____/_____
SOCIAL SECURITY # _____ MEMBER # _____
GROUP # _____ EMPLOYER: _____

EMERGENCY CONTACT
NAME: _____ PHONE # _____
NAME: _____ PHONE # _____

I hereby authorize Greenawalt Chiropractic permission to treat _____.

_____ _____
Name Signature

HIPPA/MEDICAL INFORMATION RELEASE:
I am aware of the Health Insurance Portability and Accountability Act, and by signing below I am authorizing any of my health records/information may be disclosed to the following friends and/or family members:

NAME _____ RELATIONSHIP _____
NAME _____ RELATIONSHIP_____
NAME _____ RELATIONSHIP_____

_____ _____
DATE SIGNATURE

ACCIDENT HISTORY

Date of Accident ___/___/___ Patient ~~Initials~~ NAME _____

Injury: Auto Work Comp Other _____

Location of Accident (City or Location) _____

To Whom was the accident reported? _____

Was an accident report filed? (Y or N) Time of accident? _____

Was a Police Report Made? (Y or N)

To Whom was a citation given? _____

Patient's Attorney Name _____
Address: _____
_____
Telephone Number: _____

Referred By: _____

History:

Driver _____ Passenger _____ Pedestrian _____ Other _____

Were you wearing a seat belt? (Y or N) Make of Vehicle _____
Traveling or stopped facing ____north ____south ____east ____west
Number of vehicles involved in the accident? _____
History of accident:

___ stopped at red light and rear ended
___ hit head on
___ car ran a stop sign or red light and hit _____area of car
___ side swiped
___ lost control of the car
___ other _____
_____
_____

Did you see the accident coming? (Y or N) Brace Yourself? (Y or N)
Did you strike any objects inside the car? (Y or N) What objects?

___ Steering Column ___ Rear view mirror
___ Dash Board ___ Windshield
___ Headrest ___ Driver side window
___ Other _____ ___ Can't remember

Did your seat or seat belt break or release upon impact? (Y or N)
Upon impact was your body thrown? How? _____
___ Forward ___Backward ___To the right ___ To the left
What part of your body did you strike? ___Arm/hand ___Back ___Neck
___Head ___Chest ___Face ___Knees ___Ankles ___Shoulder
Were you cut? (Y or N) Did you remain conscious? (Y or N)
Were you able to get out of the car and stand or walk? (Y or N)
Was your car towed away? (Y or N)
Was an ambulance called? (Y or N)

OVER . . . . .

Did you feel any immediate pain? (Y or N) If yes, Where?

___ Headache	Right	Left	Both	sides
___ Neck pain	Right	Left	Both	sides
___ Midback pain	Right	Left	Both	sides
___ Low Back pain	Right	Left	Both	sides
___ Shoulder pain	Right	Left	Both	sides
___ Face pain	Right	Left	Both	sides
___ Elbow pain	Right	Left	Both	
___ Wrist pain	Right	Left	Both	
___ Hand pain	Right	Left	Both	
___ Knee pain	Right	Left	Both	
___ Ankle pain	Right	Left		
___ Foot pain	Right	Left		

After the accident, did you: ___ go home ___ go to hospital
___other_____
If you went to hospital, how did you get there?_____
Name of hospital? _____ Name of physician? _____
Were you seen in the emergency room or admitted? _____
If admitted how long was your stay? _____
What was done at the hospital?

___ Examined	___ Xrays taken	___ Cervical collar
___ Medicated	___ Therapy	___ Stitches
___ Lab work	___ Casts	___ other _____

After your release what did you do? _____
What other doctors did you consult? When? _____
Doctor's name _____
Specialty?_____
What treatment did this other doctor perform?

___ xrays	___ examination	___ diathermy
___ ultrasound	___ traction	___ physiotherapy
___ prescription	___ manipulation	___ other _____

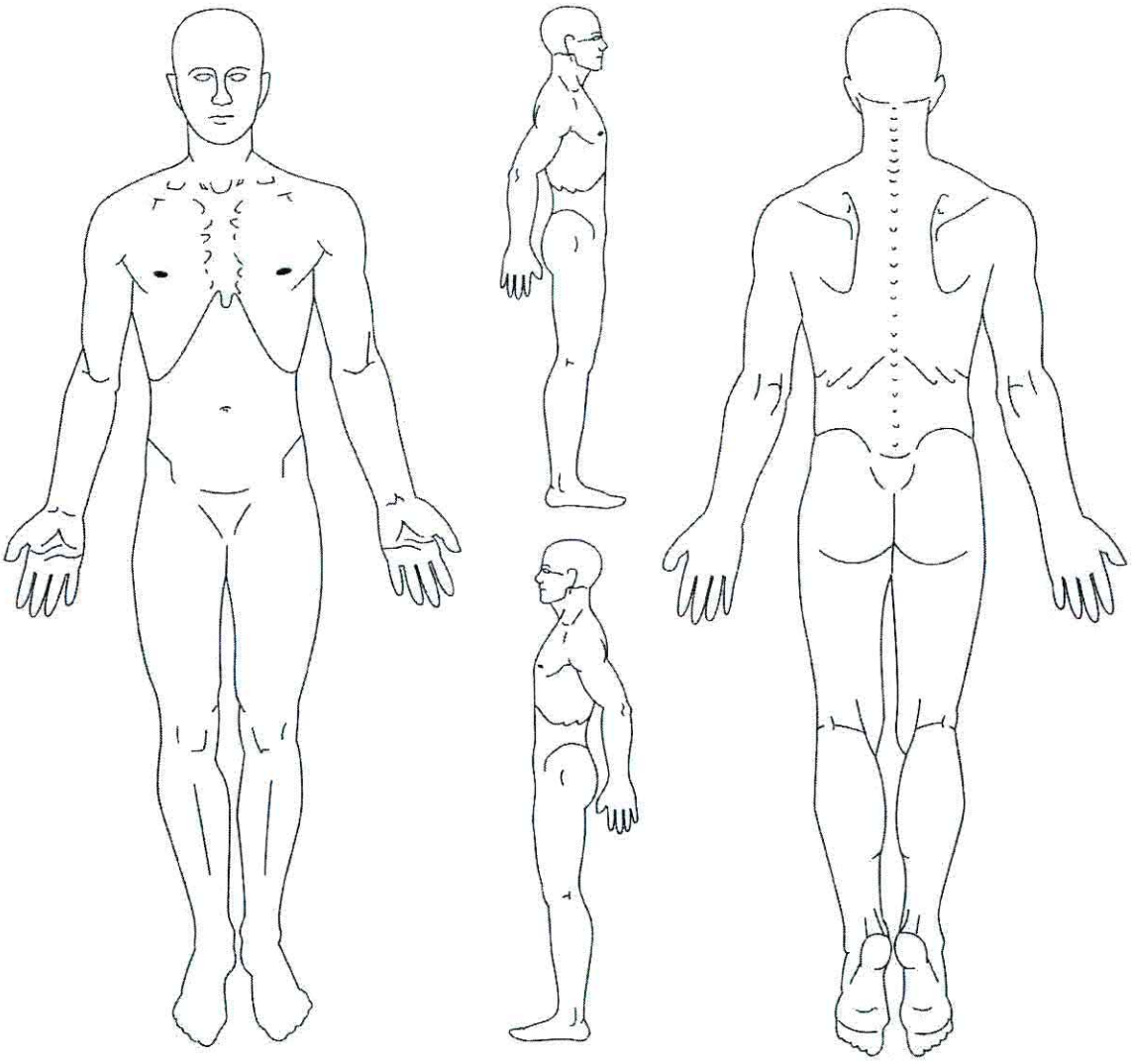
If physiotherapy was rendered, for how long? _____
Did you receive these treatments in his office? _____
How many times per week were you treated? _____
How long were you under his care? _____
Are you still under his care? _____
Did this doctor refer you to another physician? (Y or N)
Whom and where?_____
Have you ever been in any previous accidents of any kind? (Y or N)
If yes, give details. _____
_____
_____
Have you ever been treated for neck or back problems prior to this accident? (Y or N) If yes, please explain. _____
_____
_____
Have you enjoyed good health prior to this accident? (Y or N) If no please explain. _____
_____
Have you lost any time from work since the accident? (Y or N) Are you still off work? (Y or N) Date returned to work? _____

Patient Name(Print)_____ _____ ___ Date_____

Patient ID # _____

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

D = Dull
B = Burning
N = Numb
S = Stabbing/Cutting
T = Tingling (Pins & Needles)
C = Cramping



On the scales below, please draw a vertical line representing your pain or discomfort:

Rate the pain you have right **now:**

No Pain — Unbearable Pain

Rate your pain at its **best** in the past week:

No Pain — Unbearable Pain

Rate your **average** pain in the past week:

No Pain — Unbearable Pain

Rate your **worst** pain in the past week:

No Pain — Unbearable Pain

REVISED OSWESTRY DISABILITY

Name _____ Date____/____/_____ File #_____

(Please Print)

This questionnaire helps us to understand how much your low back pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

SECTION 1 - Pain Intensity

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is severe.
- ☐ The pain is severe and does not vary much.

SECTION 2 - Personal Care (Washing, Dressing, etc.)

- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increase the pain, but I manage not to change my way of doing it.
- ☐ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain, I am unable to do some washing and dressing without help.
- ☐ Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3 - Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

SECTION 4- Walking

- ☐ I have no pain on walking.
- ☐ I have some pain on walking but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than 1/2 mile without increasing pain.
- ☐ I cannot walk more than 1/4 mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5 - Sitting

- ☐ I can sit in any chair as long as I like without pain.
- ☐ I can sit only in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ I avoid sitting because it increases pain immediately.

SECTION 6 - Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on standing, but it does not, increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than 1/2 hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing, because it increases the pain immediatley.

SECTION 7 - Sleeping

- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of pain, my normal night's sleep is reduced by less than 1/4.
- ☐ Because of pain, my normal night's sleep is reduced by less than 1/2.
- ☐ Because of pain, my normal nights sleep is reduced by less than 3/4.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 - Social Life

- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal, but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

SECTION 9 - Traveling

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling, but none of my usual forms of travel make it any worse.
- ☐ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while traveling which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except that done lying down.

SECTION 10 - Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates, but overall is definitely getting better.
- ☐ My pain seems to be getting better, but improvement is slow.
- ☐ My pain is neither getting better nor getting worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Form by N. Hudson-Cook, K. Tomes-Nicholson, A. Breen. In Roland MO, Jenner JR. Eds. Back Pain. Manchester University Press 1989; 187-204

ROLAND MORRIS DISABILITY INDEX

Name _____ **Date** ____/____/____ **File#**_____
(Please Print)

When your back hurts, you may find it difficult to do some of the things you normally do. Check the box before each sentence that describes you today. Leave the box blank if the sentence does not describe you.

- ❑ I stay home most of the time because of my back.
- ❑ I change positions frequently to try and get my back comfortable.
- ❑ I walk more slowly than usual because of my back.
- ❑ Because of my back , I am not doing any of the jobs that I usually do around the house.
- ❑ Because of my back, I use a handrail to get upstairs.
- ❑ Because of my back, I lie down to rest more.
- ❑ Because of my back , I have to hold on to something to get out of an easy chair.
- ❑ Because of my back, I try to get other people to do things for me.
- ❑ I get dressed more slowly because of my back.
- ❑ I only stand up for short periods of time because of my back.
- ❑ Because of my back, I try not to bend or kneel.
- ❑ I find it difficult to get out of a chair because of my back.
- ❑ My back is painful almost all of the time.
- ❑ I find it difficult to turn over in bed because of my back.
- ❑ My appetite is not very good because of my back.
- ❑ I have trouble putting on my socks (stockings) because of my back.
- ❑ I only walk short distances because of my back pain.
- ❑ I sleep less well because of my back pain.
- ❑ Because of my back pain, I get dressed with help from someone else.
- ❑ I sit down for most of the day because of my back.
- ❑ I avoid heavy jobs around the house because of my back.
- ❑ Because of my back pain, I am more irritable and bad tempered with people than usual.
- ❑ Because of my back, I go upstairs more slowly than usual.
- ❑ I stay in bed most of the time because of my back.

Form by Roland M, Morris R. Spine 1983;8(2):141-144. Lippincott-Raven Publishers

NECK DISABILITY INDEX

Name_____ Date_____/_____/_____ File #_____
(Please Print)

This questionnaire helps us to understand how much your neck pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

SECTION 1 - Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2 - Personal Care (Washing, Dressing etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 - Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are coveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 - Reading

- ☐ I can read as much as I want to with no pain in my neck
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

SECTION 5 - Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

From Vernon H, Mior S. JMPT 1991; 14(7): 409-415

SECTION 6 - Concentration

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

SECTION 7- Work

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

SECTION 8 - Driving

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I can't drive my car at all.

SECTION 9 - Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr.sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs.sleepless.).
- ☐ My sleep is moderately disturbed (2-3 hrs.sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs.sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs.sleepless).

SECTION 10 - Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

GREENAWALT CHIROPRACTIC
PERSONAL INJURY POLICIES

We thank you for choosing Greenawalt Chiropractic for your care following your personal injury. Please read the policies of our practice, if you have any questions please do not hesitate to talk to the office manager or biller.

We no longer accept any slip and fall personal injuries where a third party is involved.

We do not accept any third party payments. If you do not have Med Pay and you are not represented by an attorney and with a signed Medical Lien, then the only way we can treat you here is if you pay cash at time of service.

We do accept personal injury auto accidents with the following restrictions:

If you are involved in an auto accident in which the other vehicle's driver was at fault and/or cited, we will bill your Med Pay on your automobile policy for payment. If your policy is exhausted, your remaining balance will be applied to your attorney Medical Lien. You may also pay cash as you go. Medical Lien must be signed, so that we have it on file.

If you are involved in an auto accident in which the other driver was at fault and/or cited but, do not carry Med Pay on your auto policy we will include your chiropractic services on a Medical Lien with an attorney.

If you are involved in an auto accident in which you are at fault and/or cited, we will bill your Med Pay.

We will NOT bill your Group Health insurance for any services for a personal auto injury. If you have an attorney in which we have a signed Medical Lien and he instructs us to bill your Group Health insurance, we will present to him this signed policy showing that you agree to the terms not to bill Group Health. ***Initial*** _____

Your account is your financial responsibility. If you discontinue treatment here, you are responsible to keep us informed as to the progression of your personal injury case and inform us as to payments.

You agree to have all payments made directly to Greenawalt Chiropractic for all services rendered here.

You agree that if you discontinue with your attorney's services , your account balance will be due in full.

You agree to cooperate with our billing staff, your attorney and or your auto insurance to get your bill paid. In the event that your attorney and/or insurance company informs us you have discontinued their services or directed them not to pay Greenawalt Chiropractic , your account may be turned over to collections and incur additional collection, service and interest fees.

By signing below you acknowledge and agree to the policy and restrictions at Greenawalt Chiropractic as listed above.

_____ _____

Signature Date

Greenawalt Chiropractic
7500 West Sahara Avenue
Las Vegas, NV 89117
702/363-8989

ASSIGNMENT OF BENEFITS AND PAYMENT AGREEMENT

THIS AGREEMENT is made and entered into by and between _____ (referred herein as "patient") and Dr. Ronald Greenawalt and/or Dr. Timothy Dutt, and/or Dr. Paul S. Green, and/or any therapist treating at our chiropractic office referred herein as Greenawalt Chiropractic. WHEREAS patient desires to receive services from Greenawalt Chiropractic and therefore desires to assign certain rights and benefits to Greenawalt Chiropractic it is hereby agreed:

a. Patient assigns to Greenawalt Chiropractic any and all benefits payable by patients insurance or health care plan(s) as a result of charges incurred by patient for services rendered by Greenawalt Chiropractic. Patient also assigns to Greenawalt Chiropractic any and all contractual rights patient has against any insurance company, health care benefit plan, or any other party contractually liable to patient for payment of health care costs incurred by patient as a result of services rendered by this chiropractic office. This assignment of benefits and contractual rights relating to those benefits includes, but is not limited to the following described policies or plans. This agreement nullifies any agreement now or in the future for any third party (attorneys) other than Greenawalt Chiropractic to receive any payments for any insurance benefits including Personal Injury Protection or Med Pay for medical services provided and billed from this office. This is the financial agreement of patient and this chiropractic office to have directly sent to Greenawalt Chiropractic as addressed above.
b. Patient hereby directs all insurers and other persons responsible for patient's health care costs to make all payments for health care services rendered by this chiropractic office directly to Greenawalt Chiropractic.
c. Patient agrees that in the event patient receives any check, draft, or other payment subject to this Agreement, such monies will be held in trust for Greenawalt Chiropractic. Patient will immediately deliver said check, draft, or payment to Greenawalt Chiropractic. Greenawalt Chiropractic agrees to apply the proceeds from said check, draft or payments to patients debt for services rendered. Any violation of this agreement will at Greenawalt Chiropractic's election terminate patient charge privileges with Greenawalt Chiropractic and bring any balance owed by patient to Greenawalt Chiropractic immediately due and payable.
d. The assignment of benefits and contractual rights shall not exceed the total amount due Greenawalt Chiropractic for service rendered by this chiropractic office. Patient agrees that payment for services rendered by Greenawalt Chiropractic is due upon receipt of said services and acceptance of patient's assignment of benefits is a convenience to patient and that Greenawalt Chiropractic may revoke this assignment at any time.

e. Patient agrees to waive any applicable statute of limitation which may at any time interfere with Greenawalt Chiropractic right to collect for services rendered by Greenawalt Chiropractic to patient.
f. Patient hereby authorizes Greenawalt Chiropractic to release and permit the examination and/or copying of any of patient's medical records, x-rays, laboratory reports and the results of all test of any time or character to such persons as Greenawalt Chiropractic deems appropriate.
g. Greenawalt Chiropractic is authorized to submit a copy of this Assignment, or notice thereof, with the initial claim form(s) or any claim thereafter which Greenawalt Chiropractic submits to third party payor(s) as notice to the third party payor(s) of the assignment and other agreements contained herein. A copy of this document shall be as binding as the document bearing original signatures. At the time each claim is submitted, a copy of the claim will be stores for safekeeping in patient's file.
h. In the event that any section or provision of this Agreement is legally void, invalid, or unenforceable, all other sections and provisions of this Agreement shall remain in full force and effect.
i. The assignments and agreements contained in this document may not be revoked by patient without the express consent of Greenawalt Chiropractic.
j. Your chosen insurance company does not guarantee benefits until claim arrives; and at that time an Explanation of Benefits will be given by your chosen insurance company stating your exact benefits. Any billing to insurance that is not covered (paid) is patient responsibility.
k. PATIENT UNDERSTANDS THAT PATIENT IS FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED BY GREENAWALT CHIROPRACTIC. ANY LEGAL OR COLLECTION EXPENSES INCURRED BY THIS OFFICE TO COLLECT BALANCE OWED BY PATIENT WILL BE THE FINANCIAL RESPONSIBILITY OF SAID PATIENT.

_____ _____

Patient's signature Date

_____ _____

Witness Date

GREENAWALT CHIROPRACTIC POLICIES

Thank you for choosing us as your healthcare provider. The following are our financial and practice policies. If you have any questions or concerns, please do not hesitate to ask our staff.

All co pays and deductibles are due at the time of service. We accept cash, checks, Visa and MasterCard. We will submit an insurance claim on your behalf. **We do not bill any secondary insurance**. If your insurance changes, you must notify us immediately, and provide us with a copy of your new insurance card prior to your next appointment. If you fail to give us your current/correct insurance information you may be held responsible for the entire bill.

All new patients to our office must provide a copy of your Driver's License and Health Insurance Card.

We schedule appointments in an effort to minimize patient waiting time. However, the doctors treat each patient individually, and therefore you may have to occasionally wait past your scheduled time. If this is an issue please schedule your appointments on a day you have a more flexible schedule or early in the morning or right after lunch.

Cancellations or changes to appointments with less than a 24 hour notice will be subject to a $25.00 fee. Initial_____

Please read the following carefully:

As a courtesy to you, we will submit your claim to your primary insurance company, but please realize that your insurance is a contract between you, your employer, and the insurance company. We are not a party to the contract. Therefore if your insurance company refuses or ignores your claims, the balance is due by you. Any claim over six months from date of service is the responsibility of the patient and/or parent if patient is a minor.

Your co-payment is an estimate of the amount you are required to pay and is due at the time of your service. We are read disclaimers by your insurance company when we are given your insurance benefits, so you may have additional amounts due. Some chiropractic services are not covered by your insurance, it is your responsibility to know what your benefits are. Vitamins, supplements, bottled water, orthotics, initial evaluations, therapy, massage and/or x-rays may not be covered by your insurance plan. We will try to get the most accurate benefit information we can from your insurance company, however, if wrong information was given and the claim item is denied, you are ultimately responsible for the bill.

Insurance companies are now pending all claims, stating that they are waiting for information from the patient. In these cases the insurance company is trying to find out if someone else could be responsible for your service such as a third party relating to an accident, or they are looking to see if you or your spouse may have additional insurance plans. In either case, this information needs to be returned immediately to your insurance company. If your claim continues to be denied, you will be sent a statement for payment in full.

HMO/PPO/MC, all may require a referral from your primary care physician before your insurance will cover your services. Your insurance may require special forms be completed specific to your particular plan, and your insurance may require prior authorization. We are NOT an HMO provider on any insurance plans. We are a PPO provider on many plans, but it is your responsibility to know if you need a referral or authorization prior to services. **Initial** _____

FEES Returned checks will be subject to a $25.00 fee. Any account with a past due balance may be sent to collections. A collection fee of 40% will be added to your account balance when it is placed in collections with the collection agency. The balance of your account including this collection fee is due by you. **Initial** _____

By signing below you agree to the following: Authorization to use this form on all insurance submissions. Authorize release of information to insurance companies to get your account paid. Authorize and assign direct payment to Greenawalt Chiropractic . And you Authorize a copy of this to be used in place of original.
I have read the financial policy described above, I understand and agree to all provisions contained within.

_____ _____

Patient Signature (Parent signature in place of minor) Date