All SPINE CHIROPRACTIC AND WELLNESS, LLC / DR. ALISSA GOULD, D.C.
126 N Main St / Cheney, KS. 67025/ Phone: 316-542-3400/ Fax: 316-542-3404

PATIENT INFORMATION:

Patient Name:_____
Date of Birth: _____ Male ___Female ____
Social Security Number: _____ -- _____ -- _____
Street: _____
City: _____
State: _____Zip: _____
Telephone: Home: (____) _____ _____
Single___ Married ___ Other___
Employed__ Full-time__ Part-Time__ Student___

Employer: _____
Employer Address: _____
City, State, Zip:_____
Work Telephone: (____) _____ _____

Relationship to Insured: ____ self ____ spouse ____ child ____ other _____
Date of Injury or Gradual Onset: _____

Insured: _____
Date of birth: _____
Social Security #: _____ / _____ / _____
Telephone: (____) _____ _____
Relationship to patient: _____

Street: _____
City: _____
State: _____ Zip: _____

Primary Insurance Company: _____
Street: _____City: _____
State:_____ Zip: _____
Telephone: (____) _____ _____
Policy#: _____ Group#: _____
Check if: ____ Worker's Compensation _____ Personal Injury _____ Auto Accident Date of Injury: _____
Claim #: _____

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PLEASE HAVE PATIENT SIGN ASSIGNMENT OF BENEFITS AND PRIVACY NOTICE

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Assignment of Benefits and Financial Agreement

I understand that All Spine Chiropractic and Wellness, LLC is an chiropractic clinic. I understand and agree that unless the doctors of All Spine Chiropractic and Wellness, LLC have a separate agreement with my insurance company, my health insurance policy is an agreement between my insurance carrier and myself. I understand that as a service to their patients, All Spine Chiropractic and Wellness, will prepare reasonably necessary reports and forms to assist me in making collection from my insurance company. I hereby authorize All Spine Chiropractic and Wellness, LLC to release any information deemed necessary and appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement, for coverage eligibility, and to representatives of any liability claims. I understand that if my insurance company requires a primary care physician referral for benefit eligibility that it is ultimately my responsibility to obtain that authorization, and agree to be responsible for all services rendered now and in the future, in the event of a denial. I also agree to be responsible for payment of services in the event of a denial from my carrier for any reason regardless of All Spine Chiropractic and Wellness, LLC contract status with my carrier. I authorize direct payment to All Spine Chiropractic and Wellness, LLC for any sum I now, or hereafter owed to All Spine Chiropractic and Wellness by any insurance company or attorney out of the proceeds of any settlement of my case. In the event the insurance plan prohibits payment to a non-participating provider, I hereby direct the plan to make any draft of payment payable to me be sent to 5931 Nieman Rd Ste 100, Shawnee KS 66203. This direction is irrevocable. I hereby authorize All Spine Chiropractic and Wellness, LLC to endorse any such check or draft on my behalf and retain those proceeds and apply them towards the balance of my account. I understand that I am ultimately responsible for payment in full to All Spine Chiropractic and Wellness, for any fees for professional services, and the costs incurred (court costs, filing fees, statements, late fees, etc.) in collecting my debt. By signing below, I am verifying that I have read and agree with the above assignment and agreement. If the patient is a minor child, my signature here also authorizes the evaluation and current / future treatment of my child by any All Spine Chiropractic and Wellness, LLC staff.
Medicare patients: Medicare does not cover this services and I agree to be responsible for the charges and pay the charges directly to All Spine Chiropractic and Wellness, LLC.

Patient / Guardian Signature_____ **Date** ___/___/___

Medical Lien:

In the case of _____(patient) who is represented by _____ _____ attorney at law, wherein _____(patient) has incurred medical expenses with All Spine Chiropractic and Wellness, LLC in the amount of $_____. I ensure that said medical provider will be paid from any insurance proceeds or other recovery through litigation or settlement. All Spine Chiropractic and Wellness, LLC agrees to withhold further billings and collection activity toward _____ (patient) until the time that settlement is finalized. Signed: (insured the/authorized person) _____ Date _____
Signed_____attorney at law. Date _____

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Notice of Receipt of Privacy Notice All Spine Chiropractic and Wellness, LLC.

All Spine Chiropractic and Wellness, LLC may use electronic transmission of images or patient information for purposes of rendering treatment, professional opinion and for payment by third party payers.

By signing below, I acknowledge that I have received and reviewed the Privacy notice of All Spine Chiropractic and Wellness, LLC, in force as of Feb 28th, 2023 and all of my questions have been answered to my satisfaction in language that I can understand.

_____ _____

Name of Individual (Printed) Signature of individual

_____ _____

Signature of Legal Representative Relationship(e.g., Attorney-In-Fact, guardian, Parent if a minor):

Date Signed ____/____/____ Witness: _____