deBarros Chiropractic Clinic
7020 Cold Harbor Rd.
Mechanicsville, VA 23111

INSURANCE INFORMATION

Patient Last Name	**First Name**	**Middle**

INSURANCE TYPE Check all those that apply

SELF INSURANCE (CONSUMER DIRECTED)
- ❑ Personal Health Insurance (not sponsored by employer)
- ❑ Health Savings Account (HSA)
- ❑ Medicare Savings Account (MSA)
- ❑ Other _____

EMPLOYER SPONSORED (PRIVATE SECTORS)
- ❑ Group Health Insurance
- ❑ Self-Funded Benefit Plan
- ❑ Private Schools
- ❑ Health Reimbursement Arrangement (HRA)

GOVERNMENTS (PUBLIC SECTORS)
- ❑ Medicare Part B
- ❑ Medicare Part C
- ❑ Medicaid
- ❑ Municipal (city, state, etc.)
- ❑ Other _____

OTHER TYPES
- ❑ Personal Injury (Auto, etc.)
- ❑ Workers' Compensation
- ❑ Church
- ❑ Other _____

INSURANCE We need a copy of your card(s) for our records.

Insurance Company _____ Phone # ( )_____
Insured's Name _____ ID/Policy # _____

Insurance Company _____ Phone # ( )_____
Insured's Name _____ ID/Policy # _____

Insurance Company _____ Phone # ( )_____
Insured's Name _____ ID/Policy # _____

RESPONSIBLE PARTY Complete this section if you are not the patient but are responsible for the bill.

Responsible Party _____
Relationship to Patient _____ SS# _____
Home Address _____ Apt# _____
City _____ State _____ Zip_____
Home Phone # _____ Work Phone # _____
Employer Name _____ Occupation _____

MY AUTHORIZATION

I authorize the **release** of any medical or other information necessary to process my claims. I also **request** payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

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

MY FINANCIAL RESPONSIBILITY

I certify that the above information is correct. I understand that I am personally **financially responsible** for all services not paid for by my insurance. I am also responsible for any annual deductibles applicable, copayments, or non-covered services as may be required by my insurance plan.

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