IMBROGNO CHIROPRACTIC & HEALING ARTS CENTER 973-783-0444

PAYMENT / INSURANCE INFORMATION

Please complete all sections that apply to you or your family member and sign where indicated.

GENERAL INFORMATION

We must have this information in the event your insurance company contacts us for information about services provided to you or your family member.

PATIENT'S NAME _____INS I.D.# _____ D.O.B. _____

INSURED'S NAME _____INS I.D.# _____ D.O.B. _____

NAME OF INSURANCE COMPANY _____

DRIVER'S LICENSE # _____ STATE _____

WE WILL NEED TO MAKE A COPY OF YOUR INSURANCE CARD and YOUR DRIVER'S LICENSE

RELEASE OF INFORMATION

I authorize the release of any medical, treatment, or other information necessary to process insurance claims.

Signed:_____ Date _____
Patient's or Authorized Person's Signature

STATEMENT OF POLICY REGARDING PAYMENT AND MEDICAL INSURANCE

IMBROGNO CHIROPRACTIC CENTER, P.A. IS NON-PARTICIPATING WITH ALL INSURANCE CARRIERS AND **DOES NOT** ACCEPT ASSIGNMENT OF INSURANCE BENEFITS. PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED. YOU WILL RECEIVE INSURANCE REIMBURSEMENT DIRECTLY FROM YOUR INSURANCE COMPANY FOR ANY COVERED SERVICES. Our office will prepare any necessary reports and forms to assist you in making collection from your insurance company; however, we cannot guarantee coverage for our services.

Signed_____ Date_____
Patient's Signature (or person responsible for payment)

FOR MEDICARE PATIENTS ONLY

Imbrogno Chiropractic Center, P.A. is a **non-participating** provider with Medicare and all other insurance companies. Payment in full is expected at the time services are rendered. Our office will submit your claims as required my Medicare. You will receive reimbursement for covered services directly from Medicare.

ATTENTION: PLEASE NOTE THE FOLLOWING:

*MEDICARE **DOES NOT** COVER THE INITIAL CONSULTATION/EVALUATION or REEVALUATIONS but WILL cover the **CHIROPRACTIC TREATMENT** portion of your first visit.

*ANY INSURANCE COMPANY may determine that your treatment is not "medically necessary". Any treatments rendered, or services provided, that are not covered by your insurance will still be the patient's financial responsibility.

Signed_____ Date_____
Insured's or Authorized Person's Signature