Patient Information (Must be Completed Before Services can be Rendered)

NAME: _____
First Middle Last

ADDRESS: _____
Street Apt. City State Zip Code

PHONE: Home_____ Work_____

SOCIAL SECURITY: _____ Marital Status: _____

Date of Birth: _____

Contact in case of emergency: _____ Phone#_____

NAME OF PRIMARY INSURANCE CARRIER: _____

Name of insured _____ Insured Date of Birth _____

Insured Social Security:_____

NAME OF SECONDARY INSURANCE CARRIER: _____

Name of insured _____ Insured Date of Birth _____

Insured Social Security:_____

Insurance Policies and Fee Schedules

- **Consultation** – Includes patient history, neurospinal exam, motion and static palpation, leg check, and heel tension.
- **Chiropractic Adjustment** – The actual re-alignment of the vertebra done manually. Often a sound will be heard, but if there is no auditory result it does not mean that the adjustment has not taken place. $40-$60
- **X-rays** – Specific x-ray views taken of your spine to determine a misalignment of our vertebrae. These can also be used to indicate progress after period of care $30-$50 per view.
- **Adjunctive Therapy** – ie: Pressure point/Trigger point therapy, Joint Mobilization, Intersegmental Traction, Manual Therapy Techniques, stretching at home instructions. Periods of resting after adjustments to let nerve system gently regain its function. $20-$40
- **Established Patient Exam** – This office visit occurs after a period of care to gain objective information and re-evaluate the person's spine. Range of motion, motion palpation, orthopedic, and/or neurological exams may be performed to determine a patient's progress. $40-$90 (All fees are standard and based on our professional association's guidelines.)

Release of Authorization/Assignment of Benefits

I authorize the release of any information necessary to process my insurance claims. I authorize and request payment of insurance benefits directly to Jeremy A. Hess, DC or Amanda Hess DC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Signed _____ Date _____