Patient Processing and Release Form

To provide testing services, the following must be completely filled out and signed.

Insurance Auto/Insurance WC Attorney Lien Cash

Referring Physician: _____

Patient Name: _____ SS #: _____
Address: _____
Street / City / State / Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone : _____ Cellular Carrier _____
DOB: _____ Sex: M F Marital Status: S M D W
Employer: _____
Address: _____
Street / City / State / Zip: _____
Fax: _____ Referred by: _____

Primary Insurance: _____
Insured Name (if not patient) _____ SS#: _____
Insured's DOB: _____
Mailing Address: _____
Telephone: _____
Policy: _____ Group #: _____
Date of Accident: _____ Claim#: _____

Secondary Insurance: _____
Mailing Address: _____
Telephone: _____
Policy: _____ Group #: _____

I authorize the following for all medical services rendered to me

1. Processing of all insurance forms by *Lukosavich Chiropractic Center*.
2. Release of all necessary information by *Lukosavich Chiropractic Center* for such processing.
3. Payment of all medical benefits directly to *Lukosavich Chiropractic Center* or their agents.
4. Appeal of insurance payments/denials at all levels.
5. A photocopy of this form may be used instead of the original.

_____ _____
Patient Signature Date

Note: Your health information will be kept strictly confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.