

**Needham Family Chiropractic**  
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## Medical Insurance

Name of Insured Policy Holder: \_\_\_\_\_

Date of Birth of Policy Holder: \_\_\_\_\_

Phone Number of Policy Holder: \_\_\_\_\_

Address of Insured Policy Holder: \_\_\_\_\_

Name of Patient: \_\_\_\_\_

Relationship to Policy Holder: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Address of Medical Insurance Company: \_\_\_\_\_

Insurance Policy ID: \_\_\_\_\_

Insurance Group #: \_\_\_\_\_

Phone Number of Insurance Company: \_\_\_\_\_

Insurance Policy Co-payment or Limits: \_\_\_\_\_

Are You Covered by a Secondary Insurance Policy or any Other Insurance?  Yes  No

If Yes, Please Provide All Information: \_\_\_\_\_

\_\_\_\_\_

**PAYMENT IS EXPECTED AT TIME OF VISIT UNLESS OTHER ARRANGEMENTS ARE MADE.**

Name of person responsible for payment: \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Needham Family Chiropractic will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. I also give Needham Family Chiropractic power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, fees for professional services rendered me will be immediately due and payable.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian or Spouse's Signature Authorizing Care: \_\_\_\_\_ Date: \_\_\_\_\_