**KIEKHOEFER CHIROPRACTIC**
8619 West Point Douglas Rd., Suite 110
Cottage Grove, MN 55016
651-458-0094

# INSURANCE INFORMATION

*Patient Information*

Last_____ First Name _____ MI_____
Address _____
City _____ State _____ Zip Code _____
Home Phone _____ Cell Phone_____ Work Phone_____
Date of Birth _____ Sex: ___ M ___F SSN#_____
Employer _____ Occupation _____
Employer address _____City _____ State _____ Zip code _____
Marital status ____Single ____married ____divorced ____widowed
E-Mail Address:_____

*Responsible Party **(If patient is a minor)***

Last Name _____ First Name _____ MI_____
Address _____
City _____ State _____ Zip Code _____
Employer _____ Occupation _____
Employer address _____City _____ State _____ Zip code _____
Marital status ____Single ____ married ____divorced ____widowed

*Insurance Information*

Primary Insurance Name_____
Identification # _____ Group Policy # _____
Policy Holder's Name _____ Policy Holder's Date of Birth _____
Policy Holder's SSN# _____ Effective Date of Policy _____
Relationship to Patient _____

*Secondary Insurance Information*

Secondary Insurance Name_____
Identification # _____ Group Policy # _____
Policy Holder's Name _____ Policy Holder's Date of Birth _____
Policy Holder's SSN# _____ Effective Date of Policy _____
Relationship to Patient _____

**Assignment & Release**

I hereby authorize payment of benefits be made directly to Kiekhoefer Chiropractic for services rendered to myself and/or dependents. I understand that I am responsible for any charges not paid by insurance. I authorize the release of any medical & billing information to my insurance company and the billing party named on behalf of me and/or my dependents.

Patient Signature_____ Date _____

**Medicare Authorization**

I request that payment of authorized Medicare Benefits be made on my behalf to Kiekhoefer Chiropractic for any services furnished by this office. I authorize any holder of medical information about me to release to Medicare & its agents any information needed to determine these benefits or the benefits payable for related services. I understand my acceptance requests that payment be made & authorizes release of medical information necessary to pay the claim. If other health insurance is indicated on the approved claim form or electronically submitted claims, my acceptance authorizes releasing the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and I am responsible only for the deductible, coinsurance, and non-covered services of this charge.

Patient Signature _____ Date _____