

Genesis Chiropractic Wellness & Rehabilitation Center

Is this visit due to an auto or workman's comp accident? NO YES

(If yes, please inform the front desk of this if you haven't already.)

Name: _____ Date: ____/____/____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Would you like text reminders? No/Yes Who is your cell phone carrier? _____

Email Address: _____ Occupation: _____

Date of Birth: _____ Gender: Male Female Social Security #: _____ - _____ - _____

Race: American Indian Asian Black or African American Native Islander White Decline

Ethnicity: Hispanic/Latino Non-Hispanic/Latino Decline Preferred Language: _____

Are you Pregnant? Yes No Number of Children: _____ Marital Status: _____

Primary Care Physician Name: _____ Clinic Name/Location: _____

Who may we thank for referring you to our office? _____

Have you had x-rays, MRI, or CT scans completed? (if yes) When/Where/Area of body: _____

Do you consume caffeine?	No/Yes	< 3 Drinks/day	3-6 Drinks/day	>6 Drinks/day
Do you consume alcohol?	No/Yes	Casual Drinker	Moderate Drinker	Heavy Drinker
Do you smoke?	No/Yes	Current Smoke (Since : _____)	Former Smoker (Quit when _____)	
Do you use drugs?	No/Yes	Recreational (_____)	Addiction	Former Addict
Do you exercise?	No/Yes	Daily	Weekly	Walks Runs Swims

List ALL Allergies (Medications/Food/Environmental) : _____

List ALL Surgeries (DATES INCLUDED): _____

List ALL Medical History conditions: _____

List ALL Medications/Vitamins you are taking (DATE STARTED as well as dosage) If you have a medication list, please provide that instead. _____

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Print Name: _____

Date: _____

Family Health History: Please write down any/all medical histories below that apply to the following family members.

Father: _____ **Mother:** _____

Brothers: _____ **Sisters:** _____

Son: _____ **Daughter:** _____

Circle any activities of daily living that are currently affected due to your pain/discomfort

Dressing, Grooming, Walking, Sitting, Standing, Sitting to Standing, In/out of bed, Transfers, Lifting, Climbing Stairs, Housework, Driving, Sleep, Childcare,

Exercises Affected? (list exercise activities) _____ Other: _____

List/Circle all Medical History conditions please read through the full list as it is important to your care and circle NONE if nothing applies.

Constitutional Systems	Unexplained weight loss, night sweats, fatigue, appetite, fever, itch/rash, recent trauma, lumps/bumps/masses, unexplained falls	NONE
Eyes	Visual changes, headaches, eye pain, double vision, blind spots,	NONE
Ears, Nose, Mouth, and Throat (ENT)	Runny nose, frequent nose bleeds, sinus pain, stuffy ears, ear pain, ringing in ears, gingival bleeding, toothache, sore throat, pain with swallowing	NONE
Cardiovascular	Chest pain, shortness of breath, trouble exercising, palpitations, fainting, loss of consciousness, calf pain when walking, high blood pressure, high cholesterol	NONE
Respiratory	Coughing, coughing blood, wheeze, shortness of breath	NONE
Gastrointestinal	Abdominal pain, difficulty swallowing, indigestion, bloating, cramping, nausea/vomiting, diarrhea/constipation, vomiting blood, abnormal stool	NONE
Genitourinary	Incontinence, blood in urine, frequent urination, trouble urinating, menopause	NONE
Musculoskeletal	Pain, stiffness, joint swelling, decreased range of motion, arthritis	NONE
Skin/Breast	Itching, rashes, wounds, tumors, eczema, excessive dryness, Breast: pain, soreness, lumps, or discharge	NONE
Neurological	Any changes in: sight, smelling, hearing, or taste. Seizures, pins and needles, numbness, weakness, poor balance, speech problems, problems with bowel/bladder control	NONE
Psychiatric	Depression, problems sleeping, anxiety, trouble concentrating, lack of energy, mood swings, change in personality	NONE
Endocrine	Hyperthyroid: prefer cold weather, mood swings, sweaty, diarrhea, weight loss. Hypothyroid: prefer hot weather, slow, tired, depressed, thin hair, constipation, dry skin Diabetes: Frequent urination, increased appetite, increased thirst, dizziness, sweating, headache	NONE
Hematological / Lymphatic	Anemia, bruising easily, family history of blood issues, history of blood transfusion	NONE

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Print Name: _____

Date: _____

For the following, please only fill out/circle what applies.

<u>NECK PAIN</u>	<u>Rate Pain</u> 0-1-2-3-4-5-6-7-8-9-10 (Mild) (Moderate) (Severe)				How did pain start?					
Date Started: _____	<u>Which side?</u> Left/Center/Right				Have you had similar pain before? (When?)					
Do you have radiating pain? (Where?)										
Is the pain... →	Constant 100-75% of time	Frequently 75-50% of time	Intermittent 50-25% of time	Occasional 25-0% of time						
Is the pain... →	Sharp	Shooting	Stabbing	Achy	Dull	Throbbing	Tingling	Numb	Burning	Tight
What time of day does your pain feel BEST →	Morning	As the day progresses	Afternoon	Evening	During the night		Stays consistent			
What time of day does your pain feel WORSE →	Morning	As the day progresses	Afternoon	Evening	During the night		Stays consistent			
What makes the pain feel better? →	Resting	Stretching	Ice	Medication	Chiropractic Care		Other:			
What makes the pain feel worse? →	Working	Standing	Twisting	Movement	Walking		Other:			

<u>UPPER/MID BACK PAIN</u>	<u>Rate Pain</u> 0-1-2-3-4-5-6-7-8-9-10 (Mild) (Moderate) (Severe)				How did pain start?					
Date Started: _____	<u>Side</u> Left/Center/Right				Have you had similar pain before? (When?)					
Do you have radiating pain? (Where?)										
Is the pain... →	Constant 100-75% of time	Frequently 75-50% of time	Intermittent 50-25% of time	Occasional 25-0% of time						
Is the pain... →	Sharp	Shooting	Stabbing	Achy	Dull	Throbbing	Tingling	Numb	Burning	Tight
What time of day does your pain feel BEST →	Morning	As the day progresses	Afternoon	Evening	During the night		Stays consistent			
What time of day does your pain feel WORSE →	Morning	As the day progresses	Afternoon	Evening	During the night		Stays consistent			
What makes the pain feel better? →	Resting	Stretching	Ice	Medication	Chiropractic Care		Other:			
What makes the pain feel worse? →	Working	Standing	Twisting	Movement	Walking		Other:			

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Print Name: _____

Date: _____

LOW BACK PAIN	<u>Rate Pain</u> 0-1-2-3-4-5-6-7-8-9-10 (Mild) (Moderate) (Severe)	How did pain start? Have you had similar pain before? (When?) Do you have radiating pain? (Where?)
Date Started: _____	<u>Side</u> Left/Center/Right	
Is the pain... →	Constant 100-75% of time Frequently 75-50% of time Intermittent 50-25% of time Occasional 25-0% of time	
Is the pain... →	Sharp Shooting Stabbing Achy Dull Throbbing Tingling Numb Burning Tight	
What time of day does your pain feel BEST →	Morning As the day progresses Afternoon Evening During the night Stays consistent	
What time of day does your pain feel WORSE →	Morning As the day progresses Afternoon Evening During the night Stays consistent	
What makes the pain feel better? →	Resting Stretching Ice Medication Chiropractic Care Other:	
What makes the pain feel worse? →	Working Standing Twisting Movement Walking Other:	

OTHER:	<u>Rate Pain</u> 0-1-2-3-4-5-6-7-8-9-10 (Mild) (Moderate) (Severe)	How did pain start? Have you had similar pain before? (When?) Do you have radiating pain? (Where?)
Date Started: _____	<u>Side</u> Left/Center/Right	
Is the pain... →	Constant 100-75% of time Frequently 75-50% of time Intermittent 50-25% of time Occasional 25-0% of time	
Is the pain... →	Sharp Shooting Stabbing Achy Dull Throbbing Tingling Numb Burning Tight	
What time of day does your pain feel BEST →	Morning As the day progresses Afternoon Evening During the night Stays consistent	
What time of day does your pain feel WORSE →	Morning As the day progresses Afternoon Evening During the night Stays consistent	
What makes the pain feel better? →	Resting Stretching Ice Medication Chiropractic Care Other:	
What makes the pain feel worse? →	Working Standing Twisting Movement Walking Other:	

Genesis Chiropractic Wellness & Rehabilitation Center

PERSONAL INJURY QUESTIONNAIRE

Name: _____ Date of accident: _____ Time: _____ A.M./P.M.

Description of accident:

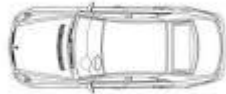
Driving Role: _____ Passenger in the back seat _____ Passenger in the front seat
_____ Driver of a motorcycle _____ Driver with both hands on the wheel
_____ Driver with left hand on the wheel _____ Driver with right hand on the wheel

Vehicle Status: _____ Accelerating _____ At a stop light _____ Attempting to stop
_____ Changing Lanes _____ Driving down the road
_____ Driving in parking lot
_____ Moving _____ Moving at moderate speed _____ Moving in reverse
_____ Parked _____ Sliding out of control _____ Slowing down
_____ Speeding _____ Spinning out of control (weather related)
_____ Stopped _____ Turning

Please circle the impact area of the vehicle:

Front

Back



Lighting Conditions: _____ Dawn _____ Dusk _____ Full Daylight _____ Night

Road Conditions: _____ Damp _____ Dry _____ Ice Covered
_____ Nasty _____ Snow Covered _____ Wet

Visibility: _____ Excellent _____ Fair _____ Good _____ Poor

Opposing Vehicle Type: _____ Compact Car _____ Full Size Car _____ Large Pickup Truck
_____ Large SUV _____ Motorcycle _____ Other _____
_____ Semi _____ Small SUV _____ Small Truck

Genesis Chiropractic Wellness & Rehabilitation Center

Opposing Vehicle Speed: _____MPH

Your Vehicle Speed: _____MPH

Headrest Position: _____High _____Low _____Middle _____Unknown

Admitted to the Hospital? _____Yes _____No

If yes when? _____At time of accident _____At a later time

Transportation to hospital? _____Ambulance _____Life Flight

_____Police Car _____Private Transportation

Bracing Status: _____Was unable to brace for impact w/my hands/feet/knees

_____Was aware that the accident was impending, but unable to brace

_____Was not aware that the accident was impending

Problems: _____By being thrown from the vehicle

_____By the seat belt

_____Hit the other passenger

_____Hit the back of the front seat

_____Hit the console

_____Hit the dashboard

_____Hit the door

_____Hit the roof of the car

_____Hit the steering wheel

_____Hit the window

_____Hit the windshield

Injury Locations: _____Back of head

_____Back of neck

_____Chest

_____Fingers on left hand

_____Fingers on right hand

_____Face

_____Forehead

_____Front of neck

_____Left Arm

_____Left elbow

_____Left hand

_____Left hip

_____Left knee

_____Left leg

_____Left shin

_____Left shoulder

_____Left Wrist

_____Low back

_____Mid back

_____Nose

_____Right Arm

_____Right elbow

_____Right hand

_____Right hip

_____Right knee

_____Right leg

_____Right shin

_____Right shoulder

_____Right wrist

_____Side of head

_____Side of neck

_____Upper back

Compromised By: _____Brightness

_____Darkness

_____Fog

_____Rain

_____Snow

_____Traffic

Feelings After the accident: _____Angry

_____Disoriented

_____Dizzy

_____Nauseous

_____Scared

_____Unconscious

_____Upset

_____Weak

Patient Signature: _____ **Date:** _____

**HIPPA – ACKNOWLEDGEMENT OF RECEIPT
Notice of Privacy Practices**

Printed **Patient** Name: _____

Patient Birth Date: _____

We at Genesis Chiropractic Wellness and Rehabilitation Center are required by law to maintain the privacy of and provide individuals with the attached Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our HIPPA Compliance Officer in person or by our main phone number. If you would like a copy of the Notice, **please ask.**

I hereby acknowledge that I have reviewed the HIPPA notice of Privacy Practice document.

Signature of patient **OR** patient's representative/parent

Date

Printed name of patient **OR** patient's representative/parent

Relationship to patient

Genesis Chiropractic Wellness & Rehabilitation Center

INFORMED CONSENT

The Nature of Chiropractic Treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a “click” or “pop” similar to the noise produced when a knuckle is “cracked,” and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, or traction may also be used.

Possible Risks: As with any health care procedures, complications are possible following a chiropractic manipulation. Complications could conceivably include fracture of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or other minor complications. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.

Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as “rare” to “extremely rare”, statistically less often than complications from taking a single aspirin tablet..

Other treatment options which could be considered may include the following:

1. *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver, and kidneys, and other side effects in a significant number of cases.
2. *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
3. *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
4. *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of Remaining Untreated: Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual Risks: I have had the following unusual risks of my case explained to me:

I have read the above explanation of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

Patient Print

Date

Patient Signature

Date

****Consent to evaluate and adjust a minor child:** I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Genesis Chiropractic Wellness & Rehabilitation Center

FEES AND PAYMENTS

Payment in full is due at the time services are rendered. We urge patients to be familiar with their chiropractic insurance benefits prior to appointment. Our office staff calls and verifies your insurance benefits if you need to be informed. Co pays and deductibles are due at time of service or your appointment may be rescheduled. If payment arrangements need to be made, please speak with our office staff to make payment arrangements. Billing your insurance company does not ensure payment, in cases of partial payment OR denial (unless stated otherwise by your insurance carrier) you are responsible for the remaining balance. You are responsible to inform our office of any changes to your insurance policy prior to your visit at our facility, not doing so can result in timely filing, in which the unpaid claim will become your responsibility.

*Patient Name Printed

*Signature

*Date

AUTHORIZED CONSENT FORM

I, _____ authorize the following people to accompany and discuss any and all chiropractic treatment at Genesis Chiropractic Wellness and Rehabilitation Center, INC. This includes any information pertaining to medical treatment, diagnosis, prognosis, and calling and scheduling/canceling appointments.

1. _____ Relationship to Patient _____
Phone # _____

2. _____ Relationship to Patient _____
Phone # _____

*Patient Name Printed

*Signature

*Date

Genesis Chiropractic Wellness & Rehabilitation Center

It has been explained to me that my health insurance company **WILL NOT** be billed for injuries that were related to any auto accident or worker's compensation claim.

I hereby authorize payment for my care to be made directly to **GENESIS CHIROPRACTIC,INC** from the responsible third party payer. If an attorney represents me, I authorize payment for my care to be issued directly to **GENESIS CHIROPRACTIC,INC.** from any settlement received in my case.

Patient Signature

Date

Office Staff Signature

Date

Genesis Chiropractic Wellness & Rehabilitation Center

ASSIGNMENT OF BENEFITS

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits to which entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical/auto plan, to issue payment check(s) directly to **GENESIS CHIROPRACTIC CLINIC, INC.** For medical services rendered to myself and/or dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize GENESIS CHIROPRACTIC CLINIC, INC. to (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from GENESIS CHIROPRACTIC CLINIC, INC. on behalf of myself and/or my dependents, and understand by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Patient/Responsible Party Signature

Date

Witness

Date

Genesis Chiropractic Wellness & Rehabilitation Center

Attorney Lien

I hereby authorize **Genesis Chiropractic Clinic, Inc.** to furnish my attorney and/or my third party insurance company with a full report of my examination, diagnosis, treatment, prognosis, and any other medical information in regards to my personal injury case.

I further authorize and direct my attorney to pay directly to **Genesis Chiropractic Clinic, Inc.** such sums as may be due and owing for medical services rendered to me by reason of this accident. All charges are to be paid at 100% of itemized costs.

I fully understand that I am directly and personally responsible **Genesis Chiropractic Clinic, Inc.** for all medical bills for services rendered and that this agreement is made solely for said clinics protection and consideration of said clinics delayed payments. I further understand that such payment is not contingent on any settlement, judgment or verdict that I may eventually recover and that payment of the account is due and payable upon demand. I further agree and understand that if I do not recover on my case, I am personally responsible for paying the doctor and will also be held responsible for paying **Genesis Chiropractic Clinic, Inc.** and will also be held responsible for any attorneys fees, collection agency costs, interest at 12% annum, court costs and any other expense incurred in order to collect the amount owed to **Genesis Chiropractic Clinic, Inc.**

Patients Signature

Date

The undersigned being the adjuster or record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to pay for the medical services rendered in regards to the above-named patient said payment shall be mailed directly to **Genesis Chiropractic Clinic, Inc. at 1024 60th Street Kenosha WI 53140.**

Attorney Signature

Date

Please sign, date and return one copy to **Genesis Chiropractic Clinic, Inc.** as soon as possible. Please retain one copy for your records.

Genesis Chiropractic Wellness & Rehabilitation Center

Auto Insurance Lien

I hereby authorize **Genesis Chiropractic Clinic, Inc.** to furnish my auto insurance company and/or my third party auto insurance company with a full report of my examination, diagnosis, treatment, prognosis, and any other medical information in regards to my personal injury case.

I further authorize and direct insurance company to pay directly to **Genesis Chiropractic Clinic, Inc.** such sums as may be due and owing for medical services rendered to me by reason of this accident. All charges are to be paid at 100% of itemized costs.

I fully understand that I am directly and personally responsible **Genesis Chiropractic Clinic, Inc.** for all medical bills for services rendered and that this agreement is made solely for said clinics protection and consideration of said clinics delayed payments. I further understand that such payment is not contingent on any settlement, judgment or verdict that I may eventually recover and that payment of the account is due and payable upon demand. I further agree and understand that if I do not recover on my case, I am personally responsible for paying the doctor and will also be held responsible for paying **Genesis Chiropractic Clinic, Inc.** and will also be held responsible for any attorneys fees, collection agency costs, interest at 12% annum, court costs and any other expense incurred in order to collect the amount owed to **Genesis Chiropractic Clinic, Inc.**

Patients Signature

Date

The undersigned being the adjuster or record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to pay for the medical services rendered in regards to the above-named patient said payment shall be mailed directly to **Genesis Chiropractic Clinic, Inc. at 1024 60th Street Kenosha WI 53140.**

Adjusters Signature

Date

Please sign, date and return one copy to **Genesis Chiropractic Clinic, Inc.** as soon as possible. Please retain one copy for your records.

Genesis Chiropractic Wellness & Rehabilitation Center

DISCLOSURE OF FEES/PAYMENT SCHEDULE

72040	AP-LAT CERV.	135.00
72050	AP-LAT CERV FLEXATION EXT	185.00
72052	AP-LAT CERV COMPLETE	220.00
72070	AP-LAT THORACIC	140.00
72100	AP-LAT L/P LUMBO/PELVIC	120.00
72114	AP-LAT L/P + OBLIQUES	190.00
72110	LUMBOSACRAL 4 VIEWS	160.00
72020	SINGLE VIEW – SPECIFIED LEVEL	60.00
73030	SHOULDER – 2 VIEWS	70.00
99201	NEW PATIENT	55.00
99202	NEW PATIENT	75.00
99203	NEW PATIENT	95.00
99204	NEW PATIENT	130.00
99211	RE-EXAM	45.00
99212	RE-EXAM	55.00
99213	RE-EXAM	70.00
99214	RE-EXAM	80.00
98940	1-2 REGIONS	60.00
98941	3-4 REGIONS	75.00
98942	5 REGIONS	95.00
98943	EXTRA SPINAL EXTREMETIES	55.00
97012	MECHANICAL TRACTION (IST)	35.00
97014	INTERFERENTIAL (IFC)	40.00
97022	WHIRLPOOL (HYDRO)	40.00
97530	THERAPUTIC ACTIVITES	45.00
97039	UNLISTED MODALITY	40.00
97035	UNLTRA SOUND (US)	40.00
97110	EXERCISES	45.00
99099	BIOFREEZE	12.66
97010C	COLD PACKS	30.00
97010H	HOT PACKS	30.00
E0943	CERVICAL PILLOW	75.00
	AVERAGE COST PER MASSAGE	60.00

I HAVE READ THE ABOVE CODES AND FEES AND UNDERSTAND THE COST OF MY CARE WITH MY TREATING DOCTOR. I FURTHER UNDERSTAND THAT IF MY TREATMENT IS ASSOICATED WITH A PERSONAL INJURY OR ACCIDENT CLAIM, ALL MEDICAL NBILLS WILL BE PAID AT 100% OF THE ABOVE FEE SCHEDULE REGARDLESS OF THE OUTCOME OF MY CASE. I UNDERSTAND THAT IF A CHECK OR DEBIT IS RETURNED FOR INSUFFICIENT FUNS, I WILL BE CHARGED A \$25 SERVICE CHARGE. I HAVE READ AND FULLY UNDERSTAND THAT ABOVE FINANCIAL TERMS AND PRICES.

Patients Signature

Date

Genesis Chiropractic Wellness & Rehabilitation Center

Personal Injury Agreement

I hereby authorize **Genesis Chiropractic Clinic, Inc.** to furnish my insurance company with a full report of my examination, diagnosis, treatment, prognosis, and any other medical information in regards to my personal injury case.

I further authorize and direct insurance company to pay directly to **Genesis Chiropractic Clinic, Inc.** such sums as may be due and owing for medical services rendered to me by reason of this accident. All charges are to be paid at 100% of itemized costs.

I fully understand that I am directly and personally responsible **Genesis Chiropractic Clinic, Inc.** for all medical bills for services rendered and that this agreement is made solely for said clinics protection and consideration of said clinics delayed payments. I further understand that such payment is not contingent on any settlement, judgment or verdict that I may eventually recover and that payment of the account is due and payable upon demand. I further agree and understand that if I do not recover on my case, I am personally responsible for paying the doctor and will also be held responsible for paying **Genesis Chiropractic Clinic, Inc.** and will also be held responsible for any attorneys fees, collection agency costs, interest at 12% annum, court costs and any other expense incurred in order to collect the amount owed to **Genesis Chiropractic Clinic, Inc.**

Patients Signature

Date

The undersigned being the adjuster or record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to pay for the medical services rendered in regards to the above-named patient said payment shall be mailed directly to **Genesis Chiropractic Clinic, Inc. at 1024 60th Street Kenosha WI 53140.**

Adjusters Signature

Date

Please sign, date and return one copy to **Genesis Chiropractic Clinic, Inc.** as soon as possible. Please retain one copy for your records.

Genesis Chiropractic Wellness & Rehabilitation Center

INSURANCE BENEFIT VERIFICATION FORM

I REQUEST THAT MY INSURANCE INFORMATION AND BENEFITS BE RELEASED TO GENESIS CHIROPRACTIC WELLNESS AND REHABILITATION.

I understand my signature requests payment information and benefits be made accessible throughout the duration of my care at this facility.

The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Print Name _____

Date _____

Signature _____

Date _____

Staff Signature _____

Date _____