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.**____

____

____

Genesis Chiropractic Wellness & Rehabilitation Center

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**

Genesis Chiropractic Wellness & Rehabilitation Center

Print Name:_________________________ Date:______________

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

NECK PAIN **Date Started:**_______	**Rate Pain** 0-1-2-3-4-5-6-7-8-9-10 (Mild) (Moderate) (Severe) **Which side?** Left/Center/Right	**How did pain start?** **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:	

UPPER/MID BACK PAIN **Date Started:**_______	**Rate Pain** 0-1-2-3-4-5-6-7-8-9-10 (Mild) (Moderate) (Severe) **Side** Left/Center/Right	**How did pain start?** **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:	

Genesis Chiropractic Wellness & Rehabilitation Center

Print Name:_________________________ Date:______________

LOW BACK PAIN **Date Started:**_______	**Rate Pain** 0-1-2-3-4-5-6-7-8-9-10 (Mild) (Moderate) (Severe) **Side** Left/Center/Right									**How did pain start?** **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:				

OTHER: _________________ **Date Started:**_______	**Rate Pain** 0-1-2-3-4-5-6-7-8-9-10 (Mild) (Moderate) (Severe) **Side** Left/Center/Right									**How did pain start?** **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:				

Genesis Chiropractic Wellness & Rehabilitation Center

WORK COMP HISTORY

Patient ____ Date: _________________

Employer's Name______________________________________ Phone: _______________

Employer's Address ____

City: __________________________________ State: _________ Zip Code: ___________

1. Type of business ______________________ Your Occupation________________________
2. Date injured _______ Hour_____AM/PM Last date worked _______ Are you off work? Y N
3. Previous Worker's Comp Injury? Y N
4. Accident reported to employer? Y N Name of person reported to____________________
5. Injured at__________________ City:______________ State:_____ Zip Code:__________
6. Length of time worked there prior to accident_______________________________________
7. Type of work being done at the time of injury_______________________________________
8. In your own words, please describe the accident

   ____

   ____
9. Have you been treated by another doctor for this accident? Y N If yes, please provide the doctor's name and address. ____

   Type of treatment received? ____

   Length of time treated by this doctor? ____

10. Have you had physical therapy? Y N If yes, what was your treatment schedule? ___________

    Does physical therapy help? Y N Not Sure

11. Prior to this accident, have you ever had any similar physical complaints to what you have now? Y N If yes, describe____

    Were these similar complaints the result of a previous accident Y N If yes, please provide details of the accident. ____

12. Have you had any other serious accidents or illnesses which required medical care or hospitalization? Y N If yes, please describe_____________________________________

    ____

13. Have you returned to work since your accident? Y N If yes, please give date returned_______

    To what capacity? _____ light duty ______ part time______ regular duty_____ full time_______

Genesis Chiropractic Wellness & Rehabilitation Center

JOB DESCRIPTION

(In terms of an 8 hour workday, "occasionally" means 33%, "frequently" means 34-66% and continuously means 67-100% of the day)

1. In a typical 8 hour workday, I (circle # of hours/activity)

Sit:	1	2	3	4	5	6	7	8	hours
Stand:	1	2	3	4	5	6	7	8	hours
Walk:	1	2	3	4	5	6	7	8	hours

2. On the job, I perform the following activities:

	NOT AT ALL	OCCASSIONALLY	FREQUENTLY	CONTINUOUSLY
Bend/Stoop	( )	( )	( )	( )
Squat	( )	( )	( )	( )
Crawl	( )	( )	( )	( )
Climb	( )	( )	( )	( )
Crouch	( )	( )	( )	( )
Kneel	( )	( )	( )	( )
Balance	( )	( )	( )	( )
Push/Paul	( )	( )	( )	( )
Reach above Shoulder level	( )	( )	( )	( )

3. On the job, I lift

	NOT AT ALL	OCCASSIONALLY	FREQUENTLY	CONTINUOUSLY
up to 10 pounds	( )	( )	( )	( )
11-24 pounds	( )	( )	( )	( )
25-34 pounds	( )	( )	( )	( )
35-50 pounds	( )	( )	( )	( )
51-74 pounds	( )	( )	( )	( )
75-100 pounds	( )	( )	( )	( )

4. Do you have to bend over while doing any lifting? Y N
5. Are your feet used for repetitive movements, such as operating foot controls? Y N
6. Do you use your hands for repetitive actions such as:

	Simple Grasping		Firm Grasping		Fine Manipulating	
Right hand	Y	N	Y	N	Y	N
Left hand	Y	N	Y	N	Y	N

7. Are you required to be around moving machinery? Y N If yes, describe _______________
____

8. Are you required to work on unprotected heights? Y N If yes, describe_______________
____
9. Are you required to drive automotive equipment? Y N If yes, describe_______________
____
10. Please list any additional comments: ____
____
____

Patient Signature____ Date ________________

Communication Method Disclosure and Consent

Genesis Chiropractic Clinic Inc communicates with its patient population in a variety of ways. We use information the patient or the patient's representative/parent provides, including landline phone, cell phone, text messaging, email, fax and U.S. mail.

By providing your **cell phone** number during the registration process, you

1. Consent and agree to receive telephone calls, text messages and other communications. These calls may be in regard to services received at Genesis Chiropractic Clinic Inc and your financial obligations related to those services. I understand this consent applies to all current and future medical service accounts for which I am the Guarantor.
2. Understand you may be charged for such calls, messages, or other communications by your wireless carrier.
3. I understand it is my responsibility to inform **Genesis Chiropractic Clinic Inc** if I choose to withdraw this permission. I can withdraw this consent at any time by contacting **Genesis Chiropractic Clinic Inc.**

I have read, fully understand, and agree to the above:

____

Print Patient OR Patient Representative/Parent Name

____ ____________

Sign Patient OR Patient Representative/Parent Name **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.

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**

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**

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

DISCLOSURE OF FEES/PAYMENT SCHEDULE

Code	Description	Fee
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**

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__________________