SpineCore Chiropractic
4300 Talbot Rd S. Ste 103, Renton, WA 98055
Tel. 425-679-9255 Fax. 425-385-0993

Patient_____

Address_____City_____

State _____ Zip Code _____

Cell Phone _____ H. Phone _____

W. Phone_____

Email Address: _____

Sex: Male / Female Marital Status: Single / Married / Other

Date of Birth_____ Age_____ Social Security # _____

Emergency Contact Name: _____ Relationship: _____

Cell Phone _____ H. Phone _____

ASSIGNMENT OF INSURANCE BENEFITS
SIGNATURE ON FILE

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this clinic chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. The clinic will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account.

*I hereby authorize payment directly to Sky Chiropractic and Massage
*I authorize Dr. Boulom, DC to act as my agent in helping me to obtain payment from the Insurance Company.
*I understand that I am financially responsible to the charges not covered by this assignment.
*I authorize the doctor, attorney, or insurance company to release any information required for this claim.
*I permit a copy of this authorization to be used in place of the original.

Signature: _____ Date: _____

Patient/ Policy Holder