West Metro Chiropractic Clinic, LTD
1710 Douglas Dr, North; Suite 222
Golden Valley, MN 55422
763-544-9667

INSURANCE INFORMATION FORM

Patient Information:

Patient Name:		Date of Birth	
Address:		City	
State	Zip	Sex:	Marital Status
Phone Number:		Patient SSN:	
Employer:		Work Phone Number:	
Emergency Contact:		Phone Number:	
How did you hear about us?			
If by referral. Who referred you?			

Responsible Party's information (if other than patient)

Legal Name		Social Security	
Address	City	State:	Zip

Primary Insurance Information:

Primary Insurance:	
Insurance Address:	
Policy Holder Name:	Policy Holder SSN:
Policy Holder Phone:	Patient's Relation to Policy Holder :
Policy Holder Date of Birth:	Employer
Group/Policy Number:	Member ID:

Please let us know if you have additional insurance coverage

Precertification/Authorization Number:

I will be paying by:	Cash:	Credit:	Credit:

I authorize the release of any medical or other information to West Metro Chiropractic Clinic, LTD. Necessary to process this claim. I also request payment of medical benefits from either a government or non-government source to West Metro Chiropractic Clinic, LTD. I authorize West Metro Chiropractic Clinic, LTD to file a complaint with the Insurance Commissioner on my behalf. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered, and I understand that I will be charged an 8% annual percentage rate with a minimum monthly fee of $1.00 on any non-contract insurance balances over 30 days. I further understand that I will be legally responsible for all collection costs involved with the collection of this account including all court costs, reasonable attorney fees and all other expenses incurred if I default on this agreement. In addition if issue a check that is returned by the bank of non-sufficient funds, I understand I will be charged $30.00 for each returned check. While West Metro Chiropractic Clinic, LTD will aide in the processing of my non-contract insurance claim, I understand that if the insurance does not pay within 60 days my account will be determined as self-pay and will be due in full. I certify that this information is true and correct to the best of my knowledge.

Signature Date