

KEMP CHIROPRACTIC CENTER

NEW PORT RICHEY, FL 34655

(727) 372-9500

Tax ID 59-3161399

Patient Name: _____

Assignment of Insurance Benefits:

I hereby authorize payment to be made directly to Dr. Andrew L. Kemp of all benefits which may be due and payable under insurance coverage for the above named patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to Dr. Andrew L. Kemp.

Authorization to Release Medical Record Information:

Dr. Andrew L. Kemp is hereby authorized to disclose all or any part of the medical records on the above named patient to such insurance companies, organizations, or agencies as may be responsible for payment of services rendered by Dr. Andrew L. Kemp. This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage for services rendered by said Dr. Andrew L. Kemp.

The undersigned certifies that He/She has read and understands each of the above paragraphs and is the patient or responsible party with the power to execute this document and accept these terms.

Signature of witness: _____

Signature of patient or responsible party: _____

KEMP CHIROPRACTIC CENTER

PLEASE PRINT

GENERAL INFORMATION:

PATIENT LAST NAME _____ FIRST NAME _____

ADDRESS _____ CARE OF _____

CITY _____ STATE _____ ZIP _____ PHONE (WORK) _____
(Parent or financially responsible person)

DRIVER'S LIC. # _____ NO. CHILDREN _____ PHONE (HOME) _____

OUT OF STATE ADDRESS _____ PHONE _____

SPOUSE'S NAME _____ SPOUSE'S EMPLOYER _____ NATIVE LANGUAGE _____

SEX M F MARRIED SINGLE WIDOWED
DIVORCED DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____
/ / - - -

PATIENT'S EMPLOYER'S NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ OCCUPATION _____

EMPLOYED

FULL TIME PART TIME
 RETIRED NOT EMPLOYED

STUDENT

FULL TIME PART TIME
 NON STUDENT

INSURANCE INFORMATION:

PATIENT NAME _____

COMMERCIAL INSURANCE AND MEDICARE ONLY

PRIMARY INSURANCE COMPANY NAME

TYPE GROUP PRIVATE

MEMBERSHIP/CERT. # _____

POLICY/GROUP# _____

COMPLETE ONLY IF PATIENT IS NOT THE INSURED

INSURED'S INFORMATION

INSURED'S NAME _____

M F MARRIED SINGLE WIDOWED

DIVORCED

PATIENT'S RELATIONSHIP TO INSURED _____

INSURED'S DATE OF BIRTH _____ / _____ / _____

INSURED'S EMPLOYER _____

SECONDARY INSURANCE COMPANY NAME

TYPE GROUP PRIVATE

MEMBERSHIP/CERT. # _____

POLICY/GROUP# _____

INSURED'S NAME _____

M F MARRIED SINGLE WIDOWED

DIVORCED

PATIENT'S RELATIONSHIP TO INSURED _____

INSURED'S DATE OF BIRTH _____ / _____ / _____

INSURED'S EMPLOYER _____

AUTOMOBILE ACCIDENT / WORKERS COMPENSATION ONLY

INSURANCE CO. _____ CLAIM # _____ POLICY # _____

ADDRESS _____ PHONE # _____

CITY _____ STATE _____ ZIP _____ ADJUSTER'S NAME _____

ATTORNEY'S NAME _____ CONTACT NAME _____ PHONE _____

ADDRESS _____

RELEASE AND ASSIGNMENT

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physicians.

Patient's Signature _____ **Date** _____