Brey Family Chiropractic, LLC

Tiffany M. Brey, D.C.
2230 Main St., Scott City, MO 63780
Ph: 573-264-1999 Fax: 573-264-1998
www.BreyFamilyChiro.com

Welcome to Brey Family Chiropractic!

First off, take a deep breath, relax, and make sure there is a smile on your face. Our primary goal is to serve you, our practice member, by providing quality chiropractic care to help you live a fuller life.

If you are looking for a friendly environment where your time is valued as much as our own, you have come to the right place. If our office ever feels cold, sterile, and uninviting, please let us know, so we can get it back to normal. If you notice me singing or dancing along with the radio, smile, laugh, close your eyes, or plug your ears, but know that I am loving my day sharing Chiropractic with our members.

We encourage you to ask questions about your health, chiropractic, living a fuller life and anything else in the vicinity. If we do not know the correct answer off hand, we will find it and get back with you. There are several natural health related magazines and articles located throughout our office, please ask if you would like a copy to share with a friend.

I look at HEALTH care as a participation sport; we each have specific roles to play to achieve our desired outcome. If you are not a chiropractic case at this time, I promise to let you know and refer you to the appropriate place. Our practice members are family, I will not refer you to anyone I would not see or send my mother to see.

It doesn't matter if you are here to keep the health you have, or to regain the health you have lost, you have made an excellent decision and will be treated well.

All care recommendations are made base on your individual case and the best projected outcome, and nothing else. There will be no additional procedures, tests, x-rays, or treatments that aren't absolutely necessary.

Our number one source of new members is direct referrals from established members. So don't be surprised when I ask for names of friends and family who you know could be living a fuller life. If you have children, please don't leave them at home! Bring them in, we are happy to do a complimentary exam on them to make sure they do not have a spinal condition that does not allow them to function at the best level. It's a whole lot more fun to grow up subluxation free with a healthy nervous system, than to be sick and down a lot of the time. Why should they have to lose their health they were born with only to try to find it again later in life?

We have children of all ages in our office, from infants to the elderly. Chiropractic allows us to live a life with a healthy nervous system, and we all can reap the benefits.

I look forward to this relationship. Welcome to Chiropractic. Welcome to our family!

Through health and wellness,

Tiffany M. Brey, D.C.

Welcome

❶ About You

Today's Date: ____/____/_____ Pt. #:________

Patient Name:_____________________________

What you Prefer to be called:________________

SS#:____________________ ☐ Male ☐ Female

Birthdate: _____/_____/_______ Age:_____

Address:__________________________________

City:________________ State: ____ Zip: ______

Home Phone: _____________________________

Work Phone:______________________________

Mobil Phone:______________________________

Email:____________________________________

Type of automatic reminder for your appointment?

☐Call Home ☐Call Cell ☐Text Cell ☐Email

Referred By:_______________________________

Employer:_________________ How Long?_____

Employer's Address_________________________

City:________________ State: ____ Zip: ______

Occupation:_______________________________

Status: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed

Spouse's Name:____________________________

Do you have children? ☐Yes ☐No How Many?___

❷ Insurance Info

Primary Insurance

Co. Name:______________________________

Address:________________________________

City:________________ State: ____ Zip:_____

Phone #:________________________________

Insured's SS#:___________________________

Patient's ID#:____________________________

Group # (Plan, Local, Policy#)____________________

Insured's Name:__________________________

Relation:_____________ DOB ____/____/____

Secondary Insurance

Co. Name:______________________________

Address:________________________________

City:________________ State: ____ Zip:_____

Phone #:________________________________

Insured's SS#:___________________________

Group # (Plan, Local, Policy#)____________________

Insured's Name:__________________________

Relation:_____________ DOB ____/____/____

Insured's Employer:_______________________

❸ Account Info

Person ultimately responsible for account

Name:_________________________________

Relation:_______________________________

Billing Address:__________________________

City:___________________ State___ Zip_____

SS#:___________________________________

Drivers License #:_________________________

Work Phone #:___________________________

Payment Method: ☐ Cash ☐Check ☐Credit

_______(Initials) I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

❹ In Event of Emergency

Who should we contact?_______________________

Relation:____________________________________

Home Phone #:_______________________________

Work Phone #:_______________________________

Who is your Medical Doctor?___________________

M.D.'s Phone #:______________________________

❺ Reason for Visit

Reason for today's visit (circle): Emergency New Injury Old Injury Chronic Pain Wellness

Are you in pain (circle) YES NO Rate your pain on a scale from 1 to 10(1=no discomfort/10=intense) ___

Did your injury occur during (circle) Work Sports/Play Auto Accident Routine/Household activity

When did your condition/accident occur? ___/___/___ Where did your injury occur?_________________

Please explain what happened:____

Is your condition getting worse? YES NO Constant Comes and goes

Is your condition interfering with your: Work Sleep Daily Routine
Is so, How: ____

Has this or something similar happened in the past? YES NO If yes, explain______________________

Have you been treated by a Medical Physician for this condition? YES NO If yes, where____________

Have you ever been treated by a Chiropractor? YES NO

Clinic/Dr.'s name ____ Clinic Phone ________________

❻ Health History

Are you taking any of the following medications? (circle) Nerve Pills Pain Killers (including aspirin)

Muscle Relaxers Blood Thinners Tranquilizers Insulin Other____

Do you have or had any of the following diseases, medical conditions or procedures?

Y N Heart Murmurs	**Y N** Heart Surg/ Pacemaker	**Y N** Heart Attack/ Stroke	**Y N** Cong. Heart Defect	**Y N** Mitral Valve Prolapse
Y N Artificial Valves	**Y N** Alcohol/Drug Abuse	**Y N** Venereal Disease	**Y N** Fainting/ Seizures/ Epilepsy	**Y N** HIV+/AIDS/ARC
Y N Shingles	**Y N** High/Low Blood Pressure	**Y N** Frequent Neck Pain	**Y N** Difficulty Breathing	**Y N** Anemia/ Diabetes
Y N Cancer	**Y N** Psychiatric Problems	**Y N** Rheumatic Fever	**Y N** Severe/ Frequent Headaches	**Y N** Kidney Problems
Y N Ulcers/Colitis	**Y N** Hepatitis	**Y N** Sinus Problems	**Y N** Emphysema/ Asthma	**Y N** Tuberculosis
Y N Glaucoma	**Y N** Chemotherapy	**Y N** Lower Back Problems	**Y N** Artificial Bones/ Joints/Implants	**Y N** Arthritis

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above:_____________
____

List any past accidents with dates:____

Please list anything that you may be allergic to:____

Family Health History:____

Do you take Supplements of Vitamins? YES NO Do you exercise? YES NO ____hours per week

Do you smoke? NO YES How much?__________ How long?________________

Are you wearing (circle) Shoe Lifts Inner Soles Arch Supports Are you dieting NO YES since ___/___/___

For women: Are you taking birth control? YES NO

Are you Nursing? YES NO Are you Pregnant? NO YES How many weeks ?_______________

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred on collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature____ Date ____/____/____
(Circle) Adult Patient Parent/Guardian Spouse

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Authorization

I certify that I have read and understand the information to the best of my knowledge. The questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Brey Family Chiropractic, LLC to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Brey Family Chiropractic, LLC, insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependent's behalf.

X

Signature of Patient (or parent of a minor) Date

I authorize Brey Family Chiropractic, LLC to send me any type of health care related publications by mail or email, such as newsletters, birthday letters, etc.

X

Signature of Patient (or parent of a minor) Date

I authorize Brey Family Chiropractic, LLC to display pictures of me / my child while being adjusted and treated (please check all that you agree to):

- ☐ Picture to be displayed on the bulletin board in the office.
- ☐ Picture to be displayed at screening events in the community.
- ☐ Picture to be displayed on our website.
- ☐ Picture to be displayed on our Facebook Page.

X

Signature of Patient (or parent of a minor) Date

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INFORMED CONSENT FOR CHIROPRACTIC CARE

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care at this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

______________________________	______________________________
Patient name (printed)	Relationship to patient
______________________________	______________________________
Patient or legal Guardian Signature	Date
______________________________	______________________________
Witness Signature (office staff)	Date

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NOTICE OF PRIVACY PRACTICES

(Medical)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordination, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer services. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to

agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our offices, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPPAA
Or to file a complaint:

The U.S. Department of Health &
Human Services
Office of Civil Rights
200 Independences Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPPA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ★ Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- ★ Obtain payment from third-party payers.
- ★ Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice to Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Relationship to Patient: ____

Date: ____

Patient Name: ____

Signature: ____

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TERMS OF ACCEPTANCE

In order to provide the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic care.

To that end, we ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this clinic:

1. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art, and practice. It is not the practice of medicine.
2. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from the normal spinal structures and configurations that interfere with normal nerve processes.
3. The chiropractic adjustment process, as defined in the “law of this jurisdiction” involves the application of a specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one-million times each day by doctors of chiropractic in the United States alone.
4. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If, during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
5. Chiropractic does not seek to replace of compete with your medical, dental, of other type(s) of health professionals. The retain responsibility for the care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
6. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.
7. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

I, ____________________ (print name) have read and fully understand the above statements.

All questions regarding the doctor’s objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

________________________________ ________________

(Signature) (Date)

Neck Disability Questionnaire

Name ______________________________ Date ______________________________

Section 1 – Pain Intensity

A) I have no pain at the moment.
B) The pain is very mild at the moment.
C) The pain is moderate at the moment.
D) The pain is fairly severe at the moment.
E) The pain is very severe at the moment.
F) The pain is the worst imaginable at the moment.

Section 2 – Personal Care

A) I can look after myself normally without causing extra pain.
B) I can look after myself normally, but it causes extra pain.
C) It is painful to look after myself and I am slow and careful.
D) I need some help, but manage most of my personal care.
E) I need help everyday in most aspects of self-care.
F) I do not get dressed; I wash with difficulty and stay in bed.

Section 3 – Lifting

A) I can lift heavy weights without extra pain.
B) I can lift heavy weights but it causes extra pain.
C) Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table)
D) Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E) I can lift very light weights.
F) I cannot lift or carry anything at all.

Section 4 – Reading

A) I can read as much as I want to with no pain in my neck.
B) I can read as much as I want with slight pain in my neck.
C) I can read as much as I want with moderate pain in my neck.
D) I cannot read as much as I want because of moderate pain in my neck.
E) I can hardly read at all because of severe pain in my neck.
F) I cannot read at all.

Section 5 – Headaches

A) I have no headaches at all.
B) I have slight headaches, which come infrequently.
C) I have moderate headaches, which come infrequently.
D) I have moderate headaches, which come frequently.
E) I have severe headaches, which come frequently.
F) I have headaches almost all the time.

Section 6 – Concentration

A) I can concentrate fully when I want to with no difficulty.
B) I can concentrate fully when I want to with slight difficulty.
C) I have a fair degree of difficulty in concentrating when I want to.
D) I have a lot of difficulty concentrating when I want to.
E) I have a great deal of difficulty concentrating when I want to.
F) I cannot concentrate at all.

Section 7 – Work

A) I can do as much work as I want to.
B) I can only do my usual work, but no more.
C) I can do most of my usual work, but no more.
D) I cannot do my usual work.
E) I can hardly do any work at all.
F) I cannot do any work at all.

Section 8 – Driving

A) I can drive my car without any neck pain.
B) I can drive my car as long as I want with slight pain in my neck.
C) I can drive my car as long as I want with moderate pain in my neck.
D) I cannot drive my car as long as I want because of moderate pain in my neck.
E) I can hardly drive at all because of severe pain in my neck.
F) I cannot drive my car at all.

Section 9 – Sleeping

A) I have no trouble sleeping.
B) My sleep is slightly disturbed (less than 1 hour sleepless).
C) My sleep is mildly disturbed (1-2 hours sleepless).
D) My sleep is moderately disturbed (2-3 hours sleepless).
E) My sleep is greatly disturbed (3-5 hours sleepless).
F) My sleep is completely disturbed (5-7 hours sleepless).

Section 10 – Recreation

A) I am able to engage in all of my recreational activities, with no neck pain at all.
B) I am able to engage in all of my recreational activities, with some neck pain.
C) I am able to engage in most, but not all of my usual recreational activities because of neck pain.
D) I am able to engage in a few of my usual recreational activities because of neck pain.
E) I can hardly do any recreational activities because of neck pain.
F) I cannot do any recreational activities at all.

Neck Disability _____ / _____ _________ % Disability

Revised Oswestry Questionnaire (Lower Back)

Name _____________________________ Date ______________________________

Section 1 – Pain Intensity

A) The pain comes and goes and is very mild.
B) The pain is mild and does not vary much.
C) The pain comes and goes and is moderate.
D) The pain is moderate and does not vary much.
E) The pain comes and goes and is severe.
F) The pain is severe and does not vary much.

Section 2 – Personal Care

A) I would not have to change my way of washing or dressing to avoid pain.
B) I do not normally change my way of washing or dressing even though it causes some pain.
C) Washing and dressing causes some pain, but I manage not to change my way of doing it.
D) Washing and dressing increase the pain and I find it necessary to change my way of doing it.
E) Because of the pain, I am unable to do some washing and dressing without some help.
F) Because of the pain, I am unable to do any washing or dressing without help.

Section 3 – Lifting

A) I can lift heavy weights without extra pain.
B) I can lift heavy weights but it causes extra pain.
C) Pain prevents me from lifting heavy weights off the floor.
D) Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table).
E) Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F) I can only lift very light weights, at the most.

Section 4 – Walking

A) Pain does not prevent me from walking any distance.
B) Pain prevents me from walking more than one mile.
C) Pain prevents me from walking more than ½ mile.
D) Pain prevents me from walking more than ¼ mile.
E) I can only walk while using a cane or on crutches.
F) I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

A) I can sit in any chair as long as I like without pain.
B) I can only sit in my favorite chair as long as I like.
C) Pain prevents me from sitting more than one hour.
D) Pain prevents me from sitting more than ½ hour.
E) Pain prevents me from sitting more than 10 minutes.
F) Pain prevents me from sitting at all.

Section 6 – Standing

A) I can stand as long as I like without pain.
B) I have some pain while standing, but it does not increase with time.
C) I cannot stand for more than one hour without increasing pain.
D) I cannot stand for more than ½ hour without increasing pain.
E) I cannot stand for more than 10 minutes without increasing pain.
F) I avoid standing because it increases the pain right away.

Section 7 – Sleeping

A) I get no pain in bed.
B) I get pain in bed, but it does not prevent me from sleeping well.
C) Because of pain, my normal night's sleep is reduced by less than one-quarter.
D) Because of pain, my normal nights sleep is reduced by less than one-half.
E) Because of pain, my normal nights sleep is reduced by less than three-quarters.
F) Pain prevents me from sleeping at all.

Section 8 – Social Life

A) My social life is normal and gives me no pain.
B) My social life is normal, but increases the degree of my pain.
C) Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g. dancing etc.)
D) Pain has restricted my social life and I do not get out very often.
E) Pain has restricted my social life to my home.
F) I have hardly any social life because of the pain.

Section 9 – Traveling

A) I get no pain while traveling.
B) I get some pain while traveling, but none of my usual forms of travel make it any worse.
C) I get extra pain while traveling, but it does not compel me to seek other forms of travel.
D) I get extra pain while traveling which compels me to seek other forms of travel.
E) Pain restricts all forms of travel.
F) Pain prevents all forms of travel except those that are done lying down.

Section 10 – Changing Degree of Pain

A) My pain is rapidly getting better.
B) My pain fluctuates, but overall is definitely getting better.
C) My pain seems to be getting better, but improvement is slow at present.
D) My pain is neither getting better nor worse.
E) My pain is gradually worsening.
F) My pain is rapidly worsening.

Oswestry_____ / _____ _________ % Disability

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | PICA

CARRIER

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

X 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

X SIGNED ______ X DATE ______

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

X SIGNED ______

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.