McKinney Family Chiropractic

700 6th Avenue
St. Albans, WV 25177
304-722-2225

INSURANCE INFORMATION

Patient Last Name _____First Name_____Middle_____

INSURANCE TYPE Check all those that apply

SELF INSURANCE (CONSUMER DIRECTED)	EMPLOYER SPONSORED (PRIVATE SECTORS)	GOVERNMENTS (PUBLIC SECTORS)	OTHER TYPES
__ Personal Health Insurance (not sponsored by employer)	__ Group Health Insurance	__ Medicare Part B	__ Personal Injury (Auto, etc.)
__ Health Savings Account (HSA)	__ Self-Funded Benefit Plan	__ Medicare Part C	__ Workers' Compensation
__ Medicare Savings Account(MSA)	__ Private Schools	__ Medicaid	__ Church
__ Other _____	__ Health Reimbursement Arrangement (HRA)	__ Municipal (city, state, etc.)	__Other_____ _____
		__ Other _____	

INSURANCE We need a copy of your card (s) for our records.

Insurance Company_____ Phone # ( ) _____
Insured's Name_____ ID/Policy# _____
Insurance Company_____ Phone # ( ) _____
Insured's Name_____ ID/Policy# _____
Insurance Company_____ Phone # ( ) _____
Insured's Name_____ ID/Policy# _____

RESPONSIBLE PARTY Complete this section if you are not the patient but are responsible for the bill.

Responsible Party _____
Relationship to Patient _____ SS# _____
Home Address _____ Apt# _____
City _____ State _____ Zip _____
Home Phone # _____ Work Phone # _____
Employer Name _____ Occupation _____

MY AUTHORIZATION

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

X_____ _____
Signature of patient or person acting on patient's behalf Date

MY FINANCIAL RESPONSIBILITY

I certify that the above information is correct. I understand that I am personally financially responsible for all services not paid for by my insurance. I am also responsible for any annual deductible applicable, co-payments, or non-covered services as my be required by my insurance plan.

X _____ _____
Signature of patient or person acting on patient's behalf Date