Kiekhoefer Chiropractic

8619 West Point Douglas Rd., Suite 110
Cottage Grove, MN 55016
651-458-0094

Patient/Insurance Information Update

Patient Information

Last_____ First Name _____ MI_____
Date of Birth _____
Address _____
City _____ State _____ Zip Code _____
Home Phone _____ Cell Phone_____
Email Address: _____

If a Minor

Name of Person Responsible for Payment _____
Cell Phone Number of Person Responsible _____
Email Address of Person Responsible _____

Primary Insurance Information

Primary Insurance Company Name_____ ID#_____ Group _____
Policy Holder's Name _____ Policy Holder's Date of Birth _____
Relationship to Patient _____

Secondary Insurance Information

Secondary Insurance Company Name_____ ID#_____ Group _____
Policy Holder's Name _____ Policy Holder's Date of Birth _____
Relationship to Patient _____

Assignment & Release

I hereby authorize payment of benefits be made directly to Kiekhoefer Chiropractic for services rendered to myself and/or dependents**. I understand that I am responsible for any charges not paid by insurance.** I authorize the release of any medical & billing information to my insurance company and the billing party named on behalf of me and/or my dependents.
Copays are due on the same date of service. If this office needs to bill you for unpaid copays, you will be assessed an additional $5.00 billing fee per monthly statement.

Patient Signature_____ Date _____

Medicare Authorization: For Medicare Patients only

Chiropractic non-covered services:	Reason Medicare may not pay:	Estimated cost:
1) Chiropractic Examinations	Items 1-5 are non-covered services and items under Medicare when delivered and/or ordered by a Doctor of Chiropractic	1) $40.00 to $80.00
2) Chiropractic X-Rays		2) $60.00 to $120.00
3) Chiropractic Extra-spinal Adjustments		3) $30.00
4) Therapy such as ultrasound, electric stim., Intersegmental traction and rehab		4) $30.00 to $50.00
5) Nutritional Supplements, ice packs, pillows, and BioFreeze		5) $1.00 to $100.00
6) Spinal Manipulation	6) Medicare may construe your spinal manipulation to be maintenance care	6) $48.00 to $72.00

I request that payment of authorized Medicare Benefits be made on my behalf to Kiekhoefer Chiropractic for any services furnished by this office. I authorize any holder of medical information about me to release to Medicare & its agents any information needed to determine these benefits or the benefits payable for related services. I understand my acceptance requests that payment be made & authorizes release of medical information necessary to pay the claim. If other health insurance is indicated on the approved claim form or electronically submitted claims, my acceptance authorizes releasing the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and I am responsible only for the deductible, coinsurance, and non-covered services of this charge.

Medicare Patient Signature _____ Date _____