Chiropractic Evolved, 7164 Hacks Cross Rd. Suite 110, Olive Branch, MS. 38654

PATIENT INFORMATION & CONDITION FORM

Patient Name: _____ Today's Date: ___/___/___

Social Security Number _____ Birth Date: ___/___/___ Age: ____ Gender: F M

Driver's License number: _____ State: _____

Patient's E-mail address: _____

If you are under 18 years of age, who are your legal parents or guardian?

Guardian: _____ Date of Birth: ___/___/___ Phone: (____) _____

Marital Status: ☐ Married ☐ Separated ☐ Widowed ☐ Single How many children? _____

CURRENT ADDRESS

Street _____

City _____ State _____ Zip _____

Phone (____) _____

Your Occupation _____ Employer _____

Work Address _____ Work Phone (____) _____

Student at _____ ☐ FULL-TIME ☐ PART-TIME

Who should we contact in the event of an emergency? _____ Relationship of emergency contact to patient: _____ Phone (____) _____

How did you learn about us? _____

Did it result from a *work-related* accident or cause? ☐ YES ☐ NO (briefly describe): _____

_____

Date of last physical examination? _____

What surgery have you had? _____ When? _____

Serious illnesses or conditions? _____ When? _____

Have you been treated for any health condition by a physician in the last year? ☐ YES ☐ NO

Describe: _____

What medications or drugs are you taking? _____

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? ☐ YES ☐ NO ☐ UNCERTAIN

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Patient Questionnaire – Non-Accident

Patient Name: _____ Today's Date: ___/___/___

Date of Exam: ___/___/___ Provider: _____ New Patient ☐ Yes ☐ No

General Information Related to the Condition:

Approximately when did the conditions or symptoms begin to occur? ___/___/___

☐ No particular condition or symptoms -- Just seeking general good health

Describe the conditions, symptoms or purpose of the appointment: _____

_____

_____

_____

Additional Information Related to the Condition:

Describe your pain: ☐ Burning ☐ Sharp ☐ Dull ☐ Ache

What caused it? _____

What aggravates it? _____

What relieves it? _____

Has the Patient ever had the same or similar condition or symptoms previous to this most recent occurrence? ☐ Yes ☐ No

When? ___/___/___

Describe: _____

_____

_____

_____

Please indicated any other healthcare providers who the Patient has seen for the condition or symptoms:

Name	Type of Licensure	Date of Last Visit
_____	_____	___/___/___
_____	_____	___/___/___

Please check any of the following symptoms you are now experiencing:

☐ Headache	☐ Dizziness	☐ Light Bothers Eyes	☐ Diarrhea	☐ Head seems too heavy	☐ Neck Pain
☐ Loss of Memory	☐ Clumsiness	☐ Feet Cold	☐ Neck Stiff	☐ Tingling in arms/hands	☐ Ears Ring
☐ Hands Cold	☐ Sleeping Problems	☐ Tingling in legs/feet	☐ Face Flushed	☐ Nausea	☐ Back Pain
☐ Numbness in arms/hands	☐ Buzzing in Ears	☐ Constipation	☐ Nervousness	☐ Numbness in legs/feet	☐ Loss of Balance
☐ Cold Sweats	☐ Tension	☐ Shortness of Breath	☐ Fainting	☐ Fever	☐ Fatigue
☐ Irritability	☐ Loss of Smell	☐ Chest pain/rib pain	☐ Pain in arms/hands	☐ Pain in legs/feet	☐ Jaw pain
☐ Loss of strength - arms	☐ Burning muscle pain	☐ Loss of strength - legs	☐ Difficulty swallowing	☐ Sharp/shooting pain	

Other _____

Have you experienced changes to:

☐ Eyes (sight) ☐ Ears (hearing) ☐ Nose (smell) ☐ Mouth (taste) ☐ Bladder

☐ Bowels ☐ Sleep ☐ Emotion ☐ Appetite

Please Explain: _____

Have you missed work or school due to your injuries? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No Number of packs: _____

Do you drink alcohol? ☐ Yes ☐ No Number of Drinks _____

Notes: _____

_____

_____

_____

Medical History:

Have you ever been in our office before? ☐ Yes ☐ No

List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date:

1) _____ ___/___/___

2) _____ ___/___/___

3) _____ ___/___/___

Surgeries/Hospitalizations: _____

Allergies (please list all): _____

Do you now or have you ever had:

☐ Heart Disease ☐ Diabetes ☐ Cancer ☐ Stroke ☐ High Blood Pressure ☐ Thyroid Problems

☐ Tuberculosis ☐ Prostate Disorder ☐ Kidney Problems ☐ Asthma ☐ Ulcer ☐ Seizure Disorder

Other: _____

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

NOTICE OF PRIVACY AND INFORMATION PRACTICES

This Notice of Privacy Practices is provided to you by **Chiropractic Evolved** (hereinafter "we" or "company") as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). It describes how we may use or disclose your protected health information, with whom that information may be shared, and the safeguard we have in place to protect it. This notice also describes your rights to access and amend your protected health information. You have the right to approve or refuse the release of specific information outside of our system except when the release is required or authorized by law or regulation.

Acknowledgement of Receipt of this Notice. You will be asked to provide a signed acknowledgement of receipt of this Notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care services will in no way be conditioned upon your signed acknowledgement. If you decline to provide a signed acknowledgement, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

Our Duties to You Regarding Your Protected Health Information (PHI). PHI is individually identifiable health information. This information includes demographics, for example, age, address, e-mail address, and relates to your past, present, or future physical or mental health or condition and related health care services. We are required by law to do the following:

1. Make sure that your PHI is kept private;
2. Give you this notice of our legal duties and privacy practices related to the use and disclosure of your PHI;
3. Follow the terms of this notice currently in effect; and
4. Communicate any changes in the notice to you.

Company reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains. Company will provide each patient with a copy of any revisions of its Notice of Information Practice at the time of their next visit, or at their last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our offices.

Permitted Uses: Treatment, Payment and Healthcare Operations. We may use and disclose protected health information for treatment, payment and healthcare operations. Treatment examples include, but are not limited to requested preschool, life insurance or sports physicals; referral to nursing homes, foster care homes, or home health agencies; or referrals to other providers for treatment. Payment examples include, but are not limited to completing a claim form to obtain payment from an insurer or activities that we might undertake to determine eligibility or coverage for benefits. Healthcare operations include, but are not limited to, investigations, implementing compliance programs, oversight or staff performance reviews, and internal quality control assurance including auditing of records.

Other Permitted Uses. Company is permitted or required to use or disclose protected health information without the individual's written authorization in certain circumstances. These include the following:

1. **Required Uses and Disclosures**. By law, we must disclose your health information to you unless it has been determined by a competent medical authority that it would be harmful to you. We must also disclose health information to the Secretary of the Department of Health and Human Services for investigations or determinations of our compliance with laws on the protection of your health information. We may use or disclose your PHI if a law or regulation requires the use or disclosure.
2. **Business Associates**. We will share your PHI with third party "business associates" who perform various activities for us. Examples are billing services or transcription services. The business associates will be required to sign a Business Associate Agreement and they will be required to protect your health information.

3. **Contacting You.** We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may call you by name in the waiting room when your health care provider is ready to see you.
4. **Treatment Alternatives.** We may use or disclose your PHI to provide you with information about treatment alternatives or other health-related benefits and services that might interest you. For example, your name and address may be used to send you a newsletter about services we offer. We may also send you information about products or services that might benefit you.
5. **Public Health.** We may disclose your PHI to a public health authority who is permitted by law to collect or receive the information. The disclosure may be necessary to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may notify the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence.
6. **Communicable Diseases.** We may disclose your PHI, if authorized by law, to a person who might have been exposed to a communicable disease or might otherwise be at risk of contracting or spreading the disease or condition.
7. **Health Oversight.** We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. These health oversight agencies might include government agencies that oversee the health care system, government benefits programs, other government regulatory programs, and civil rights laws.
8. **Food and Drug Administration.** We may disclose your protected health information to a person or company required by the FDA to do the following: report adverse events, product defects, or problems and biologic product deviations; tract products; enable product recalls; make repairs or replacements; or conduct post-marketing surveillance as required.
9. **Legal Proceedings**. We may disclose PHI during any judicial or administrative proceeding, in response to a court order or administrative tribunal (if such a disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.
10. **Law Enforcement.** We may disclose PHI for law enforcement purposes, including responses to legal proceedings, information requests for identification and location, circumstances pertaining to victims of a crime, deaths suspected from criminal conduct, crimes occurring at our office site, and medical emergencies believed to result from criminal conduct.
11. **Coroners, Funeral Directors and Organ Donations.** We may disclose PHI to coroners or medical examiners for identification to determine the cause of death or for the performance of other duties authorized by law. We may also disclose PHI to funeral directors if authorized by law. PHI may be used and disclosed for cadaveric organ, eye, or tissue donations.
12. **Research.** We may disclose your PHI to researchers when authorized by law, for example, if their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.
13. **Criminal Activity.** Under applicable federal and state laws, we may disclose your PHI if we believe that its use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.
14. **Military Activity and National Security**. When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities believed necessary or appropriate military command authorities to ensure the proper execution of the military mission including determination of fitness for duty; (2) for determination by the Department of Veterans Affairs of your eligibility for benefits; or (3) to a foreign military authority if you are a member of that foreign military service. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities including protective services to the President or others.
15. **Workers' Compensation**. We may disclose your PHI to comply with workers' compensation laws and other similar legally established programs. We will act consistently with the law of the Commonwealth of Pennsylvania and will make disclosures following such laws.
16. **Inmates**. We may use or disclose your PHI if you are an inmate of a correctional facility, and we created or received your PHI information while providing care to you. This disclosure would be necessary (1) for the institution to provide you with care, (2) for your health and safety or that of others, or (3) for the safety and security of the correctional institution.

17. **Parental Access**. We may use or disclose PHI to parents, guardians and persons acting in a similar legal status. We will act consistently with the law of the Commonwealth of Pennsylvania and will make disclosures following such laws.
18. **Family Members**. Unless you object, we may release protected health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends the condition that you are in. You will be provided a form to list specific people who we may speak to regarding your medical care. In addition, we may disclose protected health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.
19. **Fundraising**. Company may use protected health information about you to contact you in an effort to raise money for our practice and its operations. We may disclose protected health information to a related foundation so that the foundation may contact you in raising money. We only would release contact information, such as your name, address and phone number and the dates you received treatment or services. If you do not want us to contact you for fundraising efforts, you must notify our practice in writing.

Authorization Required. Company will not make any other use or disclosure of your protected health information without your written and valid authorization. Such use or disclosure must be consistent with such authorization. Authorization is specifically required for the following:

1. **Psychotherapy Notes.** We must obtain an authorization for any use or disclosure of psychotherapy notes, except: to carry out the following treatment, payment, or health care operations: (A) use by the originator of the psychotherapy notes for treatment; (B) use or disclosure by the covered entity for its own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling; or (C) use or disclosure by the covered entity to defend itself in a legal action or other proceeding brought by the individual.
2. **Marketing**. We must obtain an authorization for any use or disclosure of protected health information for marketing, except if the communication is in the form of: (A) A face-to-face communication made by a covered entity to an individual; or (B) A promotional gift of nominal value provided by the covered entity. If the marketing involves financial remuneration to us from a third party, the authorization must state that such remuneration is involved.
3. **Sale of protected health information.** We must obtain an authorization for any disclosure of protected health information which is a sale of protected health information. The authorization must state that the disclosure will result in remuneration to the covered entity.

Revoking Authorization. You may revoke the authorization at any time provided that the revocation is in writing, except to the extent that: (A) we have not taken action in reliance thereon or (B) if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Patient Rights. Patients have been granted individual rights under the HIPAA Legislation. These include the following:

1. **Inspect and copy**. You have the right to inspect and copy protected health information that may be used to make decisions about your care. You have the right to a paper copy. Usually, this includes medical and billing records, but does not include psychotherapy notes, information complied in reasonable anticipation of or use in a civil, criminal or administrative action or proceeding, or Protected Health Information that is subject to or exempt from the Clinical Laboratories Act of 1988. To inspect and copy protected health information that may be used to make decisions about you, you must submit your request in writing us. If you request a copy of the information, we may charge a fee for the costs of copying (including labor), mailing or other supplies associated with your request.
2. **Amend**. If you feel that protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is maintained in the designated record set. To request an amendment, your request must be made in writing and submitted to us. You must provide a reason that supports your request and we may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that was not created by us, unless the person or entity that created the information is no longer available to make the amendment, is not part of the protected health information kept by or for our practice; is not part of the information which you would be permitted

to inspect and copy; or is accurate and complete. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to protected health information, you may request that the denial be reviewed. Another licensed health care professional chosen by our organization will review your request and the denial. The person conducting the review will not be the person who denied your request and we will comply with the outcome of the review.

3. **Accounting of disclosures**. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of protected health information about you that was not made for treatment, payment and health care operations and there are certain exceptions to this right. To request this list or accounting of disclosures, you must submit your request in writing to us. Your request must state a time period, which may not be longer than six years prior to the date you request the accounting. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. The accounting must be provided to you no later than 60 days after the receipt of your request, unless we utilize the 30-day extension period.
4. **Restrictions on uses or disclosures**. You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to us. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse. Either you or we may terminate the restriction upon notification of the other.
5. **Confidential communications**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to us. We will ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
6. **Complaints**. You may complain to us and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. It is Company's policy that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards. You may file a Complaint with us by sending a written complaint to us.

You will be asked to outline or define specific instances or information that you would like kept completely confidential (between you and us). If you have any questions regarding this Notice of Privacy Practices, please do not hesitate to contact us for more information or clarification. You may contact the following:

NAME: _____ **PHONE:** _____

The effective date of this agreement is this _____ day of _____, 20____

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have received a copy of _____ Notice of Privacy Practices.

_____ _____

Signature of patient or personal representative Date

_____

If signed by personal representative, relationship to patient

Chiropractic Evolved

DR. NIKOLAS CHILLIES

7164 Hacks Cross Road, Suite110, Olive Branch, MS 38654

Phone: 662-420-7073/Fax: 662-420-7581

Informed Consent – Chiropractic Care & Massage

Patient's Name: _____

Instructions: This document relates to your Informed Consent for care. Please read carefully before signing.

General. I, the below-signed patient/individuals, have read this document and Care Plan in their entirety and understand the potential benefits and risks of the Care which you are recommending. I understand that there may be other forms of care which I may wish or need to seek provided by other health care practitioners. I also understand that there may be significant risks of not seeking any care for my condition.

I understand that while the Care Plan lists you as the "Rendering Provider," at any moment, other associates or staff in your office with appropriate scopes of practice and training may need to provide the Recommended Care based on factors which are not necessarily within anyone's ability to predict. You have made it clear that every health care practitioner who is licensed under state law may have different scopes of practice relating diagnoses and treatment and that the licenses of the primary Rendering Provider are listed below.

I do not expect you to be able to anticipate and explain all risks and complications, or forms of treatment, and I wish to rely on you to exercise judgment within your scope of practice during the course of the Care Plan which you feel at the time based upon the facts known. I understand that in rare cases, underlying physical defects, deformities or pathologies may render me susceptible to injury. It is my responsibility to make known before and throughout the Care whether I am suffering from any latent pathological defects, illnesses, or deformities that would otherwise not come to your attention, as well as any pathological defects, illnesses, or deformities I may be experiencing.

Possible Risks of the Care; Alternatives

Chiropractic manipulation / adjustment. As with any healthcare procedure, I understand that there are certain complications, which may arise during chiropractic manipulation, and that those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I understand that fractures are rare occurrences and generally result from some underlying weakness of the bone. I also understand that stroke and other complications are also generally described as "rare."

X-Rays. I have been advised that x-rays can be hazardous to an unborn child. To the best of my knowledge, I am not pregnant.

Other Potential Alternatives. I understand that other treatment options for my condition may include: Self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; hospitalization with traction; and surgery.

Contraindications to Manipulation / Adjustment. I understand that you will not give me an adjustment / manipulation, x-rays, modalities, or therapies if you feel that such are contraindicated. In the event that the Care does not include such procedures, I have discussed all contraindications with you and fully understand them.

Massage Therapy. Includes the assessment and treatment of the soft tissues and joints of the body, using soft tissue manipulation, joint mobilization, hydrotherapy, remedial exercises and self-care programs as determined by the therapist. Treatment plans will be discussed in advanced with the client and must be agreed upon prior to start.

Definitions. "You" and "office" refer to any provider who renders care to me at the Location above. "Care" includes all care outlined in my Care Plan as well as any other care I receive from you in the future, including care related to other conditions.

Patient's Consent. I have thoroughly discussed and reviewed my recommended Care with you, as well as your examination, diagnoses, and thoughts regarding my condition, and also all of the information in this Informed Consent. I have had ample opportunity to explore other potential forms of care, have asked you all of the questions that I have, and have no additional questions. I voluntarily and knowingly elect to receive the recommended Care.

Patient's Name: _____

Patient's Signature: _____

Date of Signature: ___/___/___

Name of Parent / Guardian / Authorized Representative: _____

Signature: _____

Date of Signature: ___/___/___

Chiropractic Evolved LLC

Financial Agreement

Patients without Insurance
We request that 100% of the first visit be paid at the time of the visit. On other visits, payment may be made at the end of the week if you sign a credit guarantee form. We are happy to accept your check, master card of Visa.

Group or Individual Insurance
Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. If is to be understood and agreed that any serviced rendered are charged to you directly and you are personally responsible for the payment of any non-covered services, deductibles or co-pays.

"On The Job" Injury (Worker's Compensation)
If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If you your employer does not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are due immediately.

Personal Injury or Automobile Accidents
Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. There are four options available to the PI patient:

Pay cash for your care and we will submit reports whenever necessary.
We will bill (accept assignment) from the Med Pay portion of your auto insurance.
We will accept a Letter of Protection or Doctor's Lien from an attorney and await payment at the time of settlement as long as you remain an active patient.
We will bill your standard health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to (six) months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

Chiropractic Evolved LLC

Financial Agreement

Medicare

We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services we provide are NON-COVERED. These services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

Flex Plans/Medical Savings Accounts

Please inform us if you have a medical savings account, sometimes known as a 'flex plan'. We will be happy to provide you with a statement of your charges for reimbursements.

Insurance forms/ Payments

If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill here.

I have read and understand the financial policy of Chiropractic Evolved LLC. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Chiropractic Evolved LLC and my insurance company. By signing below, I acknowledge that Chiropractic Evolved LLC will provide chiropractic services to me and I agree to bear full financial responsibility for all services provided. I acknowledge that I will be responsible for the full amount billed, even if the insurance company allows less than the billed amount.

Patient Signature (or guardian if patient is minor)_____

Date_____