# 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 medicals 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 _____
*(Parent or financially responsible person)*

CITY _____ STATE _____ ZIP _____ PHONE (WORK) _____

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** _____