Carmen M. Clemenson, D.C.

Clemenson Chiropractic
960 Barrington Pkwy
Marion, IA 52302
Telephone: (319) 377-1043
Fax: (319) 377-8180

Insurance Information:

Who is responsible for this account? ________________________________Relationship to patient____________
Insurance Company ____
Group#____ Policy ID#_____________________________________
Insurance is through what Business or Group? ____
Subscriber's Name _______________________________ Birth date________________SS#____________________
Subscriber's address ________________________________City_________________State______Zip___________
Subscriber's Home Phone (   )_______________Work Phone (   )_______________Cell Phone (   )____________

Is Patient covered by additional insurance? YES NO
Insurance Company ____
Group#____ Policy ID#_____________________________________
Insurance is through what Business or Group? ____
Subscriber's Name _______________________________ Birth date________________SS#____________________
Relationship to patient ____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _________________________________and Assign directly to Dr. Carmen M. Clemenson all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Carmen M. Clemenson may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor.

____Date_________________________
Signature of Patient, Guardian or Personal Representative

____Relationship to Patient__________________
Please Print name of Patient, Guardian or Personal Representative