Winters®
Chiropractic & Physical Therapy

Updated Patient Information

Date _____

Patient Name _____

Address _____

_____

Phone Numbers:

Cell _____

Home _____

Work _____

Insurance

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assigns directly to Winters Chiropractic & Physical Therapy, Inc. 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Responsible Party Signature Relationship