Auto or Work Injury Insurance Intake Form

Name_____ DOB_____

Claim #_____

Policy/Group #_____

Name of Primary Insured, if other than Patient_____

Social Security #_____

Insurance Company Name_____

Insurance Company Billing Mailing Address_____

Insurance Contact Agent, Claim Handler or Adjuster_____

Contact Agent Phone # and/or e-mail address_____

Date of Accident_____

Referring Physician/Chiropractor and clinic name_____

Physician's Phone # and/or e-mail address_____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to People-Centered Therapies, LLC DBA The Wellness Center MN all insurance benefits, if any, otherwise payable to me for services rendered. I acknowledge that cash rates do not apply towards insurance billed services. I understand that I am financially responsible for all charges including collection costs and attorney fees, whether or not paid by insurance. I agree to notify People-Centered Therapies, LLC DBA The Wellness Center MN of any communication about my insurance benefits or independent medical exam. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party_____

Relationship_____ Date_____