

**River North Chiropractic
401 W. Ontario St
Suite 100
Chicago, IL 60601**

Please fill out the form below and fax to (847)515-4771 and we will let you know what your Chiropractic benefits are.

PATIENT INFORMATION:

Name: _____ Date of Birth: _____ SS# _____

Home Address _____ Apt# _____

City _____ State _____ Zip _____

Home Phone # _____ Work Phone # _____

Employer Name _____ Occupation _____

INSURANCE We need a copy of your card(s) for our records.

Insurance Company _____ Phone # _____

Insured's Name _____ ID/Policy # _____

RESPONSIBLE PARTY Complete this section if you are not the patient but are responsible for the bill.

Responsible Party _____

Relationship to Patient _____ SS# _____

Home Address _____ Apt# _____

City _____ State _____ Zip _____

Home Phone # _____ Work Phone _____

Employer Name _____ Occupation _____

My Authorization

I authorize the **release** of any medical or other information necessary to process my claims. I also **request** payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

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Signature of patient or person acting on patient's behalf

Date



Phone: 847-515-4771 Fax: 847-515-4747 E-mail: a.b.s@comcast.net