INSURANCE INFORMATION FORM**: Health Insurance**
Please give your insurance ID and Drivers License to the Front Desk

Are you the primary holder on your insurance: ___Yes ___No, if no:

Primary Ins Holder:_____

Date of Birth:_____ Social Security Number:_____

Do you have additional insurance coverage? If so, give the ins card to the front desk.

Assignment and Release:

I certify that I have read and completed the above information accurately and to the best of my knowledge. I understand that I am ultimately financially responsible for payment of ALL services rendered on my behalf whether or not said services are covered by my insurance benefits. I understand and agree that insurance policies are an arrangement between the insurance carrier and myself and not the doctor. I authorize Hands on Health to release all information necessary (diagnosis, medical records, etc) to third party payers and other health practitioners. I authorize the use of this signature on all insurance submissions. I authorize and direct my insurance company to pay benefits and direct payment may be mailed to Hands on Health at 311 S. Pennsylvania, Denver, CO 80209.

_____ _____
Patient Signature Date

Automobile Accident Insurance Information:

Date of Loss: _____ Were you at fault? ___ Yes ___ No

Your auto ins carrier: _____ Claim #: _____

Adjustor:_____ Phone Number:_____

Other drivers ins carrier: _____Claim#: _____

Adjustor:_____ Phone Number: _____

Was a citation given ___ Yes ___ No, to: _____

Do you have an attorney: ___Yes ___No,

Name: _____ Phone Number:_____

I have read the Assignment and Release and agree to all terms.

_____ _____
Patient Signature Date