Lindvig Family Chiropractic
1510 2nd Ave W Suite 202, Williston, ND 58801
PH: (701) 572-0884 | williston@twwclinics.com
www.thewellnessway.com

PERSONAL INFORMATION

Date: _____ First Name: _____Middle: _____Last: _____

Date of Birth: _____ SSN: _____ Sex: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Marital Status: _____

Emergency Contact: _____ Relationship: _____

Emergency Phone: _____

Whom may I thank for referring you? _____

How did you hear about our office? □Newspaper □Family/Friend □Facebook □Google □Event

Occupation: _____ Employer: _____

PAYMENT OPTIONS

☺ **SELF PAY** (no insurance)

☺ **INSURANCE**

Lindvig Family Chiropractic will file chiropractic claims with the following insurance companies (**ACTIVE CARE ONLY**):

Choose One: ☺Blue Cross Blue Shield ☺Sanford Health Plan □ND Medicaid □Medicare
**Please bring your insurance card with to your first appointment*.
**It is the patient's responsibility to check insurance coverage.*

Please Initial:

_____ I authorize Lindvig Family Chiropractic to release all information necessary to any insurance company for the purpose of claim reimbursement of charges incurred by me.

_____ I understand verifying insurance benefits does not guarantee payment from my insurance company.

_____ I understand and agree that my health insurance policies are an arrangement between the insurance carrier and myself.

_____ I understand and agree that all services rendered to me are my financial responsibility and that I am responsible for timely payment.

By signing below, I agree to the financial policy described above.

_____ _____
Signature Date