Helios Chiropractic and Wellness Center
Linda Capra, DC
815 Main Street
Menomonie, WI 54751
715-235-7333

PERSONAL INFORMATION:

Name: _____

Address: _____

City: _____ State: _____ Zip _____

Home Phone: _____ Work Phone: _____

E-mail Address: _____

Birth Date: _____ Age: _____ Sex: _____ Student: Y N

Marital Status: Sgl Mar Div Sep Wid

Place of Employment: _____

Address: _____

Social Security #: _____

INSURANCE CARRIER INFORMATION: *Please put your insurance information here.*

Primary Insurance Company: _____

Name of Policy Holder: _____

ID Number _____ Group Number _____

Billing Address _____

City: _____ State: _____ Zip: _____

Relationship to the insured: Self Spouse Child Other

Secondary Insurance Company: _____

Name of Policy Holder: _____

ID Number _____ Group Number _____

Billing Address _____

City: _____ State: _____ Zip: _____

Are you the Guarantor? Y N If not, who is? _____

Please turn page over ⇨

I authorize payment of Medical Benefits to Helios Center. I authorize release of any medical information necessary to process claims, and/or I also request payment of government benefits either to Helios Center. I also am responsible for all insurance co-payments, deductibles, and denials that may occur. I understand that if I do not have insurance coverage, that I am responsible for my bill and will pay on time. I have also read the Privacy Practices Policy for Helios Center.

*Signature: _____ Date: _____

INSURED INFORMATION: ***Please fill this section out only if the responsible party and/or*** *insured party is different from above.*

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Place of Employment: _____

Social Security # _____ Date of Birth:_____

Relationship to the insured: Self Spouse Child Other

ACCIDENT/INJURY ONLY: *Please fill this section out **only** if there was an accident, personal injury or Workman's Comp case.*

Is your condition related to any type of work injury, car accident or other injury?

Yes No Car Accident
Yes No Work Injury
Yes No Other Accident

If so please state the date of the injury: _____

Please also list the proper insurance to bill.
Name of Company: _____

Address: _____

City:_____ State: _____ Zip: _____

Phone: _____ Contact Person: _____

Claim number: _____

WELLNESS/WHOLENESS CHOICE: *Please fill this section out only if you choose one of the Helios Wellness Plans. Please understand that this care is not yet covered by most insurance companies.*

I understand I am responsible for my payment plan and will choose accordingly.

_____ _____
Signature Date