PATIENT: Fill out the personal information requested on your insurance co. claim form and attach this statement to it. This statement contains all the information the doctor is required to supply.

ATTENDING PRACTITIONER'S STATEMENT
(CHARGE SLIP AND RECEIPT)

INSURANCE CARRIER: This statement has been adopted to keep paperwork down. Any additional form or itemized bills will be forwarded upon a receipt of $_____

Patient's Name: _____ Date of Service: _____

NEW PATIENT (Office Visit) **Fee**
- ☐ 99201 Self Limited or Minor _____
- ☐ 99203 Moderate Severity _____
- ☐ 99204 Moderate to High Severity _____

ESTABLISHED PATIENT (Office Visit)
- ☐ 99211 Minimal _____
- ☐ 99212 Self Limited or Minor _____
- ☐ 99213 Low to Moderate Severity _____
- ☐ 99214 Moderate to High Severity _____

ACUPUNCTURE PROCEDURES
- ☐ 97035 Ultrasound, ea. 15 min. _____
- ☐ 97110 Therapeutic Proc., ea. 15 min. _____
- ☐ 97112 Neuromuscular Reeducation _____
- ☐ 97124 Massage Therapy _____
- ☐ 97139 Unlisted Therapeutic Proc. _____
  Specify_____
- ☐ 97140 Manual Therapy Techniques _____
  (Manipulation, Myofascial Release, Manual Traction, Mobilization) 1 or more regions, ea. 15 min.
- ☐ 97799 Unlisted Phys. Med. Serv. _____
  Specify_____
- ☐ 97802 Med. Nutrition, Indiv., Init. _____
- ☐ 97803 Med. Nutrition, Indiv., Subseq. _____
- ☐ 97810 One or more Needles without _____
  Elec. Stim. Initial 15 minutes
- ☐ 97811 Each additional 15 minutes _____
  without Elec. Stim.
- ☐ 97813 One or more Needles with _____
  Elec. Stim. Initial 15 minutes

White - Office Copy Yellow - Insurance Copy Pink - Patient's Copy

#400-AC MISSION PRINTING (559) 227-7640 (800) 693-2108

Fee
- ☐ 97814 Each Additional 15 minutes _____
  with Elec. Stim.
- ☐ _____ _____ _____
- ☐ _____ _____ _____

MODALITIES
- ☐ 97010 Hot/Cold Treatment _____
- ☐ 97012 Traction, Mechanical _____
- ☐ 97039 Unlisted Modality _____
  Specify_____

MISCELLANEOUS
- ☐ 99056 Home Services _____
- ☐ 99070 Supplies/Materials _____
  (Not included in office visit)
- ☐ Herbs ☐ Needles ☐ Supplements _____
- ☐ 99080 Special Reports (UCR) _____
- ☐ **Other** _____ _____

TOTAL _____

Old Balance $_____
Today's Charges $_____
TOTAL $_____
Payment Received $_____
New Balance $_____

NEXT APPOINTMENT:

DATE_____ TIME_____

Place of service ☐ Office ☐ Hospital ☐ Home

ICD-9-CM CODES (Diagnosis) _____

AUTHORIZATION TO RELEASE INFORMATION: I authorize the release of any information requested to process this claim.

Signed:

ASSIGNMENT OF BENEFITS: I authorize payment to be made directly to the below named healthcare provider. I understand I am responsible for charges not covered by this assignment.

Signed:

Date first consulted:
Mo. _____ Day _____ Year _____

☐ New Case ☐ Continued Claim
☐ Total Disability ☐ Partial Disability
☐ Related to: _____
Disability from _____ to _____
Date to return to work_____

_____
PROVIDER'S NAME TYPED DEGREE

S.S.# or I.R.S.# _____
LIC. # _____ Phone # _____
Address_____

_____
Provider's Signature

PATIENT: Fill out the personal information requested on your insurance co. claim form and attach this statement to it. This statement contains all the information the doctor is required to supply.

ATTENDING PRACTITIONER'S STATEMENT
(CHARGE SLIP AND RECEIPT)

INSURANCE CARRIER: This statement has been adopted to keep paperwork down. Any additional form or itemized bills will be forwarded upon a receipt of $_____

Patient's Name: _____ Date of Service: _____

NEW PATIENT (Office Visit) Fee
☐ 99201 Self Limited or Minor _____
☐ 99203 Moderate Severity _____
☐ 99204 Moderate to High Severity _____

ESTABLISHED PATIENT (Office Visit)
☐ 99211 Minimal _____
☐ 99212 Self Limited or Minor _____
☐ 99213 Low to Moderate Severity _____
☐ 99214 Moderate to High Severity _____

ACUPUNCTURE PROCEDURES
☐ 97035 Ultrasound, ea. 15 min. _____
☐ 97110 Therapeutic Proc., ea. 15 min. _____
☐ 97112 Neuromuscular Reeducation _____
☐ 97124 Massage Therapy _____
☐ 97139 Unlisted Therapeutic Proc. _____
Specify_____
☐ 97140 Manual Therapy Techniques _____
(Manipulation, Myofascial Release, Manual Traction, Mobilization) 1 or more regions, ea. 15 min.
☐ 97799 Unlisted Phys. Med. Serv. _____
Specify_____
☐ 97802 Med. Nutrition, Indiv., Init. _____
☐ 97803 Med. Nutrition, Indiv., Subseq. _____
☐ 97810 One or more Needles without _____
Elec. Stim. Initial 15 minutes
☐ 97811 Each additional 15 minutes _____
without Elec. Stim.
☐ 97813 One or more Needles with _____
Elec. Stim. Initial 15 minutes

White - Office Copy Yellow - Insurance Copy Pink - Patient's Copy

#400-AC MISSION PRINTING (559) 227-7640 (800) 693-2108

Fee
☐ 97814 Each Additional 15 minutes _____
with Elec. Stim.
☐ _____ _____ _____
☐ _____ _____ _____

MODALITIES
☐ 97010 Hot/Cold Treatment _____
☐ 97012 Traction, Mechanical _____
☐ 97039 Unlisted Modality _____
Specify_____

MISCELLANEOUS
☐ 99056 Home Services _____
☐ 99070 Supplies/Materials _____
(Not included in office visit)
☐ Herbs ☐ Needles ☐ Supplements _____
☐ 99080 Special Reports (UCR) _____
☐ Other _____ _____

TOTAL _____

Old Balance $_____
Today's Charges $_____
TOTAL $_____
Payment Received $_____
New Balance $_____

NEXT APPOINTMENT:

DATE_____ TIME_____

Place of service ☐ Office ☐ Hospital ☐ Home

ICD-9-CM CODES (Diagnosis) _____

AUTHORIZATION TO RELEASE INFORMATION: I authorize the release of any information requested to process this claim.

Signed:

ASSIGNMENT OF BENEFITS: I authorize payment to be made directly to the below named healthcare provider. I understand I am responsible for charges not covered by this assignment.

Signed:

Date first consulted:
Mo. _____ Day _____ Year _____

☐ New Case ☐ Continued Claim
☐ Total Disability ☐ Partial Disability
☐ Related to: _____
Disability from _____ to _____
Date to return to work_____

_____
PROVIDER'S NAME TYPED DEGREE

S.S.# or I.R.S.# _____
LIC. # _____ Phone # _____
Address_____

_____
Provider's Signature