<u>PATIENT:</u> 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.

**NEW PATIENT (Office Visit)** 

ATTENDING PRACTITIONER'S STATEM	<b>IEN</b>
(CHARGE SLIP AND RECEIPT)	

Fee

Patient's Name:

Fee

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

Date of Service:

Place of service			□ Home
ICD-9-CM CODI	ES (Diagno	osis)	

99201 Self Limited or Minor	.  97814 Each Additional 15 minutes	_ ICD-9-CM CODES (Diagnosis)
99203 Moderate Severity	with Elec. Stim.	
99204 Moderate to High Severity	· □	
ESTABLISHED PATIENT (Office Visit)		
□ 99211 Minimal	MODALITIES	<ul> <li>AUTHORIZATION TO RELEASE INFORMATION: I authorize the release of any information requested to process this claim.</li> </ul>
99212 Self Limited or Minor		
99213 Low to Moderate Severity		_ Signed:
99214 Moderate to High Severity	$\Box$ 97012 Traction, Mechanical	ASSIGNMENT OF BENEFITS: I authorize payment to be made directly to the below named healthcare provider.
ACUPUNCTURE PROCEDURES	97039 Unlisted Modality	_ I understand I am responsible for charges not covered by this assignment.
□ 97035 Ultrasound, ea. 15 min.		assignment.
□ 97110 Therapeutic Proc., ea. 15 min □ 97112 Neuromuscular Reeducation		Signed:
□ 97112 Neuromuscular Reeducation	99056 Home Services	<ul> <li>Date first consulted:</li> </ul>
□ 97139 Unlisted Therapeutic Proc.	99070 Supplies/Materials	Mo Day Year
Specify	(Not included in office visit)	
□ 97140 Manual Therapy Techniques	(Not included in office visit)         .       □ Herbs       □ Needles       □ Supplements	<ul> <li>Total Disability</li> <li>Partial Disability</li> </ul>
(Manipulation, Myofascial Release, Manual Traction, Mobilization) 1 or more regions,	99080 Special Reports (UCR)	
ea. 15 min.	□ Other	
97799 Unlisted Phys. Med. Serv.		
Specify □ 97802 Med. Nutrition, Indiv., Init.	TOTAL	
□ 97802 Med. Nutrition, Indiv., Int.	Old Balance \$	_
□ 97810 One or more Needles without	Today's Charges \$	
Elec. Stim. Initial 15 minutes	TOTAL \$	Dedite
97811 Each additional 15 minutes	Payment Received \$	- S.S.# or I.R.S.#
without Elec. Stim.	New Balance \$	LIC. # Phone #
Elec. Stim. Initial 15 minutes		Address
	NEXT APPOINTMENT:	
White - Office Copy Yellow - Insurance Copy Pink - Patient's Copy	NEXT AT FORTIMENT.	
PATIENT: Fill out the personal information requested on your insurance co. claim form and attach this statement to	ATTENDING PRACTITIONER'S STATEMENT	
your insurance co. claim form and attach this statement to it. This statement contains all the information the doctor is	(CHARGE SLIP AND RECEIPT)	keep paperwork down. Any additional form or itemized bills will be forwarded upon a receipt of \$
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your insurance co. claim form and attach this statement to it. This statement contains all the information the doctor is required to supply. NEW PATIENT (Office Visit) Fee	(CHARGE SLIP AND RECEIPT) Patient's Name: Fee	keep paperwork down. Any additional form or itemized bills will be forwarded upon a receipt of \$ Date of Service: Place of service □ Office □ Hospital □ Home
your insurance co. claim form and attach this statement to it. This statement contains all the information the doctor is required to supply. NEW PATIENT (Office Visit) 99201 Self Limited or Minor	(CHARGE SLIP AND RECEIPT) Patient's Name: Fee 97814 Each Additional 15 minutes	keep paperwork down. Any additional form or itemized bills         will be forwarded upon a receipt of \$         Date of Service:         Place of service         Office       Hospital         Home         ICD-9-CM CODES (Diagnosis)
your insurance co. claim form and attach this statement to it. This statement contains all the information the doctor is required to supply. NEW PATIENT (Office Visit) 99201 Self Limited or Minor 99203 Moderate Severity	(CHARGE SLIP AND RECEIPT) Patient's Name: Fee 97814 Each Additional 15 minutes with Elec. Stim.	keep paperwork down. Any additional form or itemized bills         will be forwarded upon a receipt of \$         Date of Service:         Place of service       Office         ICD-9-CM CODES (Diagnosis)
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Tour insurance co. claim form and attach this statement to it. This statement contains all the information the doctor is required to supply.       Fee <ul> <li>99201</li> <li>Self Limited or Minor</li> <li>99203</li> <li>Moderate Severity</li> <li>99204</li> <li>Moderate to High Severity</li> </ul> Fee                99201         Self Limited or Minor <li>99203             Moderate Severity</li> <li>99204</li> <li>Moderate to High Severity</li> <ul> <li>99211</li> <li>Minimal</li> <li>99212</li> <li>Self Limited or Minor</li> <li>99213</li> <li>Low to Moderate Severity</li> <li>99214</li> <li>Moderate to High Severity</li> </ul> <ul> <li>ACUPUNCTURE PROCEDURES</li> <li>97035</li> <li>Ultrasound, ea. 15 min.</li> <li>97110</li> <li>Therapeutic Proc., ea. 15 min.</li> <li>97112</li> <li>Neuromuscular Reeducation</li> <li>97124</li> <li>Massage Therapy</li> <li>97139</li> <li>Unlisted Therapeutic Proc.</li> <li>Specify</li> <li>97140</li> <li>Manual Therapy Techniques</li></ul>	(CHARGE SLIP AND RECEIPT)         Fee         97814       Each Additional 15 minutes         with Elec. Stim.	keep paperwork down. Any additional form or itemized bills will be forwarded upon a receipt of \$         Date of Service:          Date of Service:          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:
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vour insurance co. claim form and attach this statement to it. This statement contains all the information the doctor is required to supply.         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         97112 Neuromuscular Reeducation       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	(CHARGE SLIP AND RECEIPT)         Fee         97814       Each Additional 15 minutes         with Elec. Stim.	Image: Authorized interview intervi

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

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\_\_\_TIME\_

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