<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.

## 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:	$\_$ Place of service $\ \sqcup$ Office $\ \sqcup$ Hospital $\ \sqcup$ Home
NEW PATIENT (Office Visit)	Fee	Fee	AUTHORIZATION TO RELEASE INFORMATION: I authorize the release of any information requested to process this claim.
<ul><li>□ 99201 Self Limited or Minor</li><li>□ 99203 Moderate Severity</li></ul>			_
☐ 99204 Moderate to High Severity		with Elec. Stim.	Signed:  ASSIGNMENT OF BENEFITS: I authorize payment to be made
<b>ESTABLISHED PATIENT (Office Visit)</b>		-	directly to the below named healthcare provider
☐ 99211 Minimal		MODALITIES	assignment.
<ul><li>□ 99212 Self Limited or Minor</li><li>□ 99213 Low to Moderate Severity</li></ul>		_	Signed:
☐ 99214 Moderate to High Severity		<del></del>	
ACUPUNCTURE PROCEDURES		□ 97039 Unlisted Modality	Mo Day Year
☐ 97035 Ultrasound, ea. 15 min.		Specify	☐ New Case ☐ Continued Claim
<ul><li>□ 97110 Therapeutic Proc., ea. 15 min.</li><li>□ 97112 Neuromuscular Reeducation</li></ul>		MISCELLANEOUS	☐ Total Disability ☐ Partial Disability
☐ 97112 Neuromuscular Reeducation		□ 99056 Home Services	· · · · · · · · · · · · · · · · · · ·
☐ 97139 Unlisted Therapeutic Proc.			
Specify  □ 97140 Manual Therapy Techniques		(Not included in office visit)	Data to return to work
(Manipulation, Myofascial Release, Manual			_
Traction, Mobilization) 1 or more regions,		☐ 99080 Special Reports (UCR)	
ea. 15 min.  ☐ 97799 Unlisted Phys. Med. Serv.			PROVIDER'S NAME TYPED DEGREE
Specify			S.S.# or I.R.S.#
97802 Med. Nutrition, Indiv., Init.			LIC. # Phone #
<ul><li>□ 97803 Med. Nutrition, Indiv., Subseq.</li><li>□ 97810 One or more Needles without</li></ul>			— Address
Elec. Stim. Initial 15 minutes		1 oday's Charges \$	
97811 Each additional 15 minutes without Elec. Stim.		,	
☐ 97813 One or more Needles with		Payment Received \$	
Elec. Stim. Initial 15 minutes		New Balance \$	Provider's Signature
IOD O OM CODES (Diamagia if not als		DIACNOCIC	
ICD-9-CM CODES (Diagnosis if not ch *5th digit required	© 692.9	Dermatitis/Eczema 715.9 Osteoarthros	is* ☐ 719.42 Upper Arm
☐ 789.0 Abdominal Pain*	□ 304.9		I Syndrome
☐ 626.0 Amenorrhea	□ 625.3	Dysmenorrhea ☐ 569.42 Rectal Pain	☐ 719.44 Hand
☐ 303.9 Alcohol Dependence* ☐ 493.9 Asthma*	□ 782.3 □ 780.7	Edema ☐ 487.1 Respiratory I Fatigue/Malaise* ☐ 714.0 Rheumatoid	
☐ 351.0 Bell's Palsy	□ 787.3	Gastric Pain	ronic)   719.47 Ankle/Foot
☐ 490.0 Bronchitis	□ 307.81		Menopausal or 723.1 Cervicalgia
☐ 727.3 Bursitis ☐ 354.0 Carpal Tunnel Syndrome	□ 346.1 □ 401.9	Headache (common migraine)*  Hypertension  Female Clim  726.90  Tendinitis NO	acteric States
☐ 786.59 Chest Pain	□ 536.8	Indigestion 388.3_ Tinnitus*	☐ 724.4 Thoracic/Lumbar Radiculitis
☐ 558.9 Colitis/Gastroenteritis NOS	□ 780.52	Insomnia 524.60 TMJ	☐ 724.2 Lumbago/Lumbalgia
☐ 564.0 Constipation* ☐ 733.6 Costochondritis	□ 626.2 □ 787.0	Menorrhagia ☐ 780.4 Vertigo NOS Nausea* JOINT PA	
☐ 595.0 Cystitis, Acute	□ 729.2	Neuritis/Neuralgia ☐ 719.41 Shoulder Re	
<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	White -	Office Copy Yellow - Insurance Copy Pink - Patient's Copy  ATTENDING PRACTITIONER'S STATEMEN (CHARGE SLIP AND RECEIPT)	keep paperwork down. Any additional form or itemized bills
your insurance co. claim form and attach this statement to		ATTENDING PRACTITIONER'S STATEMEN	INSURANCE CARRIER: This statement has been adopted to keep paperwork down. Any additional form or itemized bills will be forwarded upon a receipt of \$
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