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 DOCTOR'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: ☐ Office ☐ Home ☐ Other

NEW PATIENT (Office Visit)

		Fee
☐	99201 Self Limited or Minor	
☐	99202 Low to Moderate Severity	
☐	99203 Moderate Severity	
☐	99204 Moderate to High Severity	
☐	99205 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	
☐	99215 Moderate to High Severity	

PROCEDURES

☐	97032 Elec. Stim. (Manual) ea. 15 min.	
☐	97035 Ultrasound, ea. 15 min.	
☐	97110 Therapeutic Proc., ea. 15 min.	
☐	97112 Neuromuscular Reeducation	
☐	97124 Massage	
☐	97139 Unlisted Therapeutic Proc. Specify_____	
☐	97140 Manual Therapy Techniques (Manipulation, Myofascial Release, Manual Traction, Mobilization) 1 or more regions, ea. 15 min.	
☐	98940 Manipulation, 1-2 regions	
☐	98941 Manipulation, 3-4 regions	
☐	98942 Manipulation, 5 regions	
☐	98943 Extraspinal, 1 or more regions	

MODALITIES

		Fee
☐	97010 Hot/Cold Treatment	
☐	97012 Traction, Mechanical	
☐	97014 Electrical Stimulation (Unatt.)	
☐	97039 Unlisted Modality Specify_____	

MISCELLANEOUS

☐	99070 Supplies/Supports	
☐	99070 Supplements	
☐	99080 Special Reports (UCR)	
☐	99080 Review of Medical Records	
☐	_____ _____	

X-RAY DIAGNOSTIC STUDIES

☐	72040 Cervical Spine/2-3v	
☐	72050 Cervical Spine/4-5v	
☐	72052 Cervical Spine/6-7v (flex-ext)	
☐	72070 Thoracic Spine/2v	
☐	72072 Thoracic Spine/3v	
☐	72080 Thoracolumbar/2v	
☐	72090 Full Spine/1v (scoliosis study)	
☐	72110 Lumbosacral Spine/4-5v	
☐	72114 Lumbosacral/6-7v (flex-ext)	
☐	72202 Sacro-iliac Joints	
☐	76140 Interpretation of X-rays	
☐	_____ _____	
☐	_____ _____	

TOTAL _____

White - Office Copy Pink - Patient's Copy

#1010-N MISSION PRINTING (559) 227-7640 (800) 693-2108

Old Balance $ _____

Today's Charges $ _____

TOTAL $ _____

Payment Received $ _____

New Balance $ _____

DIAGNOSIS: _____

_____

Date first consulted _____

Date of disability _____

☐ New Case ☐ Continued Claim

☐ Total Disability ☐ Partial Disability

Disability from _____ to _____

Date to return to work _____

ASSIGNMENT AND RELEASE: I hereby authorize and direct my insurance benefits to be paid directly to the Doctor. I am financially responsible for non-covered services. I also authorize the Doctor to release any information required.

Signed: _____ Date: _____

Doctor's Name _____

S.S. # or I.R.S. # _____

Phone # _____

Address _____

_____

_____

Doctor's Signature