A Few Last Details....

Name_____Birth_____/_____/_____

Type of Work_____Employer_____

Who referred you to Dr. Brennan?_____

Medical Doctor_____Phone_____

Name of any Specialist seen in the last 12 months_____

Would you like a copy of our privacy statement? _____

IMPORTANT INSURANCE INFORMATION

Our office is contracted with Medical Mutual of Ohio and *Medicare. Please give the staff your insurance card to photo copy.
Please be aware that you may have copays and/or an annual deductible required by your insurance.

I grant permission to release any information necessary to process my bills, and assign payment to Dr. Brennan.

Patient Signature_____Date_____

All other patients will be charged $85 for the initial visit with Dr. Brennan. Follow up visits are $40. These discounted fees are to be paid during your visit.

***MEDICARE NOTE: Medicare and supplemental insurance does not pay for initial examinations or any therapy. Medicare will only pay for spinal manipulation that is considered active treatment (not maintenance treatment). The new patient exam is $85. Therapy is $40 per visit. These charges cannot be billed to any secondary insurance, and are due during the visit.**

MINORS

Dr. Brennan has permission to treat my minor child:_____

Parent signature_____Date_____