

## Patient and Insurance Information

Name	Date	
Address	Apt #	
City	State	ZIP
<b>Health Insurance Info</b>		
Carrier	Ins Co	phone
Address		
Policy #	Group #	
Patient Relationship to the insured    Self    Spouse    Child    Other		
If you are covered under another person's insurance.... Please complete		
Name of Insured		
Address of insured		
Phone of insured	Sex	Birth date
Insured's    Employer		
Address		
Employer Phone		Plan Name

### Designation of Authorized Representative

I, \_\_\_\_\_, do hereby designate Dr. Kimberlee Wilkens and Wilkens Chiropractic (hereafter referred to as "my doctor"), to the full extent permissible under the Employee Retirement Income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b)4 to act on my behalf to pursue claims and exercises all rights connected with my employee health care benefit plan with respect to any medical or other healthcare expenses incurred as a result of the services I received from the above named doctor. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records and to claim on my behalf such medical or other health care service benefits, insurance or health care benefit plan reimbursement and to pursue any other applicable remedies all in connection with medical or other health care expense(s) as the result of the services I received from my doctor.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Date