STATEMENT OF ACCOUNT

Statement No:

Date:

Billing Period:

PATIENT INFORMATION

Name:

Address:

Phone:

DOB:

INSURANCE / CASE DETAILS

Carrier:

Policy ID:

Claim No:

Group No:

DATE	CPT CODE	DESCRIPTION OF SERVICE / MODALITY	SPINAL REGION(S)	CHARGES ($)	PAYMENTS ($)

DATE	CPT CODE	DESCRIPTION OF SERVICE / MODALITY	SPINAL REGION(S)	CHARGES ($)	PAYMENTS ($)

Total Charges:

Insurance Paid:

Patient Paid:

Adjustments:

Balance Due:

Authorized Signature

Date

Thank you for choosing our clinic for your chiropractic care and wellness journey.