SUPERBILL

	Procedure	Code	Fee		Procedure	Code	Fee
	Spinal (3-4)	98941	$50.00		Electrostim	97014	$31.00
	OV Detailed	99203	$105.00		Ultrasound	97035	$30.00
	Moderate E&M	99213	$65.00		Traction K S	97012	$36.00
	SRS	S9090	$45.00		X-Ray Exam		$_____
	Support/ Misc.		$_____		X- Ray Exam		$_____
	Other		$_____		X-Ray Exam		$_____

Height _____ Weight____	If Female – Pregnant? (Circle One) Yes No	Total Fee $ _____ Amount Paid $ ____

Name: _____
Last First Middle Initial

Street Address: _____
Address City State Zip

Work Telephone: ( ) _____-_____ **Ext.**_____ **Home Telephone:** ( ) _____-_____

Social Security Number: _____-____-_____ **Date of Birth:** _____/_____/_____

Insurance Company: _____
Name Address City State Zip

Policy Number: _____ **Group Number:** _____

Policy Holder: _____ **D.O.B.**____/____/____ **S.S. #** _____-_____-

E-Mail Address :_____ **PHONE:**_____

Subjective (For Office Use Only) _____

Objective (For Office Use Only) _____

_____

_____ **B. P.**_____/_____

Diagnosis (For Office Use Only) _____

Treatment Plan (For Office Use Only)

_____

_____

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS TO DR. PERSHING. I AUTHORIZE PAYMENT OF ANY MEDICAL BENEFITS TO DR. PERSHING.

_____ __/__/__ _____ __/__/__
Patient's Signature Today's Date Physician's Signature Today's Date

If the Patient is a minor child I have legal authority and give permission to treat my child.

Next Appointment Time