

**PATIENT INFORMATION**

Name \_\_\_\_\_ Marital Status: S / M / D / W  
                    First Name                      Middle Initial                      Last Name  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_  
Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_ Birth Date \_\_\_\_\_  
Sex ( ) M ( ) F Age \_\_\_\_\_ Referred by: \_\_\_\_\_  
Permission to discuss case with PCP? Yes / No    PCP # \_\_\_\_\_ PCP Name: \_\_\_\_\_  
*The following person(s) have my permission to receive my personal health info:*

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

**The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA Notice that is available to you at the front desk before signing this consent.**

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature Authorizing Care: \_\_\_\_\_ Date: \_\_\_\_\_

**RESPONSIBLE PARTY**

( ) SAME AS ABOVE

Name \_\_\_\_\_ Home Phone# \_\_\_\_\_  
                    First Name                      Middle Initial                      Last Name  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_ DOB \_\_\_\_\_  
Employed By \_\_\_\_\_ Work Phone # \_\_\_\_\_  
Business Address \_\_\_\_\_

**INSURANCE COVERAGE**

**Primary Insurance Company:** \_\_\_\_\_ Phone#: \_\_\_\_\_  
Group Name and Number: \_\_\_\_\_ PPO / HMO  
Policy/Subscriber/ID #(s): \_\_\_\_\_  
Claims Address: \_\_\_\_\_

**Secondary Insurance Company:** \_\_\_\_\_ Phone#: \_\_\_\_\_  
Group Name and Number: \_\_\_\_\_ PPO / HMO  
Policy/Subscriber/ID #(s): \_\_\_\_\_  
Claims Address: \_\_\_\_\_

**FOR OFFICE USE ONLY**

Contact person: \_\_\_\_\_ Dx. /Complaint: \_\_\_\_\_  
Are chiropractic services covered? \_\_\_\_\_ Coverage Effective Date: \_\_\_\_\_  
Deductible: \_\_\_\_\_ Met? \_\_\_\_\_ Family Ded: \_\_\_\_\_ Met? \_\_\_\_\_  
Out of Pocket: \_\_\_\_\_ Met? \_\_\_\_\_ Co-Pay/% \_\_\_\_\_ Exam/Office Visit \_\_\_\_\_  
X-ray \_\_\_\_\_ Rehab/PT \_\_\_\_\_ PMT \_\_\_\_\_ DME \_\_\_\_\_  
Is a referral or authorization needed for services? Yes / No  
**Limits:** Max # visits per year \_\_\_\_\_ Max \$ per visit \_\_\_\_\_ Max \$ per year \_\_\_\_\_  
Any specific condition exclusions? \_\_\_\_\_  
Any pre-existing conditions? \_\_\_\_\_  
Personal Injury Claim? \_\_\_\_\_  
Notes:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_