Date: ______________ Patient Name: ____Patient DOB: _______________

Patient Injury / Chief Complaint:____

Home Address: ____Marital Status: M S W D

City:____ State: _______ Zip: ____________

Phone H: _______________________ W: _________________________ C: _______________________

Email Address:____

We do not leave detailed messages on answering systems or with individuals other than you unless otherwise notified by you. We will only notify you to contact our office. We will use your email address for purposes of monthly blasts informing you of helpful information concerning our practice, and classes/events you may wish to attend. This information is confidential and will not be released to anyone.

Name of Primary Insured: __________________________ Primary's Employer: ____________________

Primary's DOB: _______________________________ Relationship to Patient:______________________

Emergency Contact: ____

Name Relationship to Patient Phone

Who may we thank for referring you:

____

Our practice utilizes a certified Electronic Medical Record software system that is in compliance with Medicare. Medicare regulates the entire health insurance industry. Because we are participating providers for several insurance carriers, we are required to obtain the following information from every patient:

Preferred Language: ☐ English / ☐ Spanish / Other:_______________________________

Race: ☐ I decline to provide / ☐ White / ☐ Black or African American / ☐ American Indian or Alaska Native / ☐ Asian/ ☐ Native American or Other Pacific Islander / Other: _______________________________

Ethnicity: ☐ I decline to provide / ☐ Hispanic or Latino / ☐ Non-Hispanic / Non-Latino / Other:______________________

Smoking Status: ☐ Everyday / ☐ Occasionally / ☐ Past / ☐ Never

Medication Allergies: ____

Current Prescription Medications: ☐ None

___________________________________mg( ) ___________________________________mg( )
___________________________________mg( ) ___________________________________mg( )
___________________________________mg( ) ___________________________________mg( )
___________________________________mg( ) ___________________________________mg( )

CONTINUE ON REVERSE

ACTION CHIROPRACTIC
AND SPORTS INJURY CENTER

Please read each section listed below, and sign in the space provided indicating you have read and understand, and will comply with our Practice policies and procedures.

► Consent to be Treated (Self) ____

A patient willfully choosing to be treated by the chiropractic physician gives the doctor permission and authority to care for him/her in accordance with chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures, including physical therapy, are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. In no way will the treating Chiropractor provide treatment or care if he/she is aware that such care may be contra-indicated.

It is the responsibility of the patient to make it known, or to learn through healthcare procedures whatever it is he/she is suffering from; latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic physician provides a specialized, non-duplicating health care service. Furthermore, any risk involved regarding chiropractic treatment will be explained to you upon your request. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen.

► Consent to be Treated (Minor) ____

Signature of Parent / Legal Guardian

A patient willfully choosing to be treated by the chiropractic physician gives the doctor permission and authority to care for him/her in accordance with chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures, including physical therapy, are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. In no way will the treating Chiropractor provide treatment or care if he/she is aware that such care may be contra-indicated.

It is the responsibility of the patient to make it known, or to learn through healthcare procedures whatever it is he/she is suffering from; latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic physician provides a specialized, non-duplicating health care service. Furthermore, any risk involved regarding chiropractic treatment will be explained to you upon your request. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen.

► General Office Policies ____

1. Cancellation or No-Show - All “no-shows”, and/or a cancellation made with less than 24 hour notice will be charged a $30.00 fee. This fee is expected prior to your next appointment.

2. Late for Appointment - If you are running late by 10 minutes or more, please give us a call. In some cases we may need to reschedule your appointment.

3. Cell Phones - Out of respect and courtesy for other patients as well as for our front office staff, please silence your phone and take your cell phone calls outside the waiting area.

I have willingly provided the information requested on page 1 and 2 of this document and confirm that the information provided is accurate and true to the best of my knowledge.

Signature (Patient and/or Parent / Legal Guardian) ____ Date ____________

CONTINUE ON REVERSE

NEW PATIENT FINANCIAL RESPONSIBILITY

Please read the section below that best describes your financial status, and initial in the space provided indicating you have read and understand, and will comply with our Practice policies and procedures.

► Health Insurance ____________

I, the undersigned, have insurance and/or employee health care benefits coverage and hereby assign and convey directly to Action Chiropractic all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim.

Your insurance is a contracted agreement between yourself and/or your employer, and the insurance company. We verify insurance coverage for our billing purposes only. Upon verification we will notify you of any special circumstances; however it is ultimately your responsibility to be aware of your coverage and any limitations. Please read your explanation of benefits mailed by your insurance to your home. This document assists you in tracking your Chiropractic coverage details. We do not track individual patient policy information.

► Private Pay (Non Insurance) ____________

Action Chiropractic & Sports Injury Center reserves the right to change service and treatment fees at any time. You may contact our office to verify our current fee schedule prior to making an appointment and/or receiving services. Private Pay patients are offered a "courtesy, time of service discount". This fee is required at the completion of each treatment session.

In accordance with health insurance regulation, our practice is not permitted to collect the private pay fee from you, AND submit to the insurance company simultaneously. Your financial status is "health insurance" OR "private pay". If at any time you wish to use your health insurance, any past treatment and fees are not eligible for submission. Upon changing your financial status to insurance, only that date of service and future dates of service are eligible for submission.

A. I do not have insurance and therefore willingly elect to privately pay for services rendered.

B. I have insurance however I willingly elect to privately pay rather than process my treatment costs through my insurance plan.

► Automobile Accidents / Workers Compensation ____________

Our office will generate the claims for your treatment and forward those claims to the responsible party using the claim number and billing information you provided. Please understand that your claim number and claim submission is never a guarantee of payment. The responsible agency will request documentation of your treatment and progress for which we are required to provide. Upon completion of their medical review, a determination will be made and payment will be generated. Any treatment cost that exceed the benefit levels you were quoted, or are denied is patient responsibility.

► Account Balances ____________

Patients with balances that fall within 31-90 days past due, will be informed of their balance at each visit and payment will be expected at the time of service. Patients with balances that fall within 90-120 days past due will be warned via letter and phone call, and if no effort is made to pay the balance and/or make special arrangements, your account will be forwarded to our third party collector, and you will not be permitted to continue treatment with us. We reserve the right to keep a credit card on file and bill you directly if you are more than 30 days delinquent.

Signature (Patient / Parent and/or Legal Guardian) ____ Date _________________

CONTINUE ON REVERSE