Integrity Chiropractic, Inc.

PATIENT INFORMATION

Full Name:_____ Social Security #_____ Today's Date_____

Address:_____City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Email:_____

Age:_____ Birth Date:_____ Sex:_____ Marital: M S W D (Circle one)

Occupation:_____Employer:_____

Employer's Address:_____Work Phone:_____

How were you referred to our office?_____

Family Medical Doctor:_____Contact Number_____

Emergency Contact Name:_____ Address:_____Phone:_____

METHOD OF PAYMENT

Please circle any and all insurance coverage that may be applicable in this case: π Major Medical π Worker's Compensation π Medicare π Auto Accident π Medical Savings Account & Flex Plans π Other_____

Name of Primary Insurance Company:_____

Name of Secondary Insurance Company (if any):_____

AUTHORIZATION, ASSIGNMENT, LIEN, AND RELEASE

I authorize payment of insurance benefits and settlement or judgement proceeds directly to Integrity Chiropractic, Inc. I grant Integrity Chiropractic, Inc. an irrevocable lien on any benefits payable to me as a result of my injuries in an amount equal to their fee for treating me. I authorize the doctor to release all information necessary to communicate with personal physicians, attorneys, adjusters, and other healthcare providers and payors and to secure the payment of benefits. This is to serve as a long-term authorization card. 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. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

INTEGRITY CHIROPRACTIC