ACTION CHIROPRACTIC

Thank you for choosing our clinic for your chiropractic care. Please complete this form **in ink.**

We are happy to help you---just ask! **Date:** _____

Last Name: _____ First Name: _____ M.I_____

Date of Birth (D.O.B.) _____/_____/_____ Age: _____ Gender: **M** **F**

Home Address: _____ Apt. #_____

City: _____ State: ____ Zip: _____ Height: ___ft. ___in. Weight: _____lbs.

Email: _____ ***Who may we thank for referring you**? _____

Home phone: _____ Cell phone: _____ Work phone: _____

Preferred places for messages? **Home** **Cell** **Work** **Email** (Circle all that apply)

Marital Status: □ Married □ Single □ Divorced □Widowed Spouse's name: _____

Women: Is there a chance you are pregnant? _____ Due date? _____

Children's names and ages: _____

_____

Your employer: _____ Job title: _____

Emergency contact: _____ Relationship to you: _____

Phone: _____ Address: _____

City_____ State_____ Zip_____

Primary Doctor (PCP)_____ Phone: _____

Have you had previous chiropractic care? No Yes Date of last care: _____

Is this an accident case? Yes No Date of accident: _____

Circumstances: Auto collision On the job Other_____

Details: _____

_____

Staff only: *BP* _____/_____ *Pulse:* _____ *Date:* _____ *Initials:* _____

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Patient Name_____Date of Birth_____

Insurance Company Name_____Subscriber's Employer_____

Subscriber's Name_____Date of Birth_____

Group #_____Contract #_____

Patient's Relationship to subscriber (Circle one): Self Spouse Child Dependent

_____I authorize BCC to copy my driver's license/personal I.D. --and insurance cards, if applicable--for my records.

Financial Responsibility With/Without Insurance: All services rendered to me are charged directly to me; I am personally and financially responsible for payment of all charges incurred at Action Chiropractic Clinic & Therapy, PLC ("ACC" or, "ACC, PLC"), including insurance deductibles, copayments, and any & all services rejected/not covered by insurance. All charges are due at the time of service unless I have signed a payment plan agreement. I instruct and direct my insurance company to pay, by check made out to and mailed directly to ACC, PLC, the professional or medical expenses benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward charges for professional services rendered by ACC, PLC; a photocopy of this assignment shall be considered as valid as the original. I authorize ACC, PLC to release any pertinent Protected Health Information (PHI) to any insurance company, adjustor, and/or attorney involved in my case, and I hereby release ACC, PLC of any consequence thereof.

Health and accident insurance policies are an arrangement between the insurance carrier and me; I am responsible for knowing my carrier's rules, regulations, and payment policies. For specific questions regarding my insurance coverage, I must contact my carrier directly. **As a courtesy**, ACC will submit insurance bills within 4 weeks of date of service; ACC has no control over insurance carriers' response time(s). As ACC will collect approximated amounts from me, I may end up with a bill or credit on my account. For any automobile accident claim(s), I am responsible for any charges rejected, deemed unreasonable or unnecessary by my automobile insurance company and/or an independent medical examination, and ACC may require another form of payment guaranty. If workman's compensation is deemed unrelated to work, I will be responsible for all services.

Delinquent accounts (over 60 days of non-payment by patient and/or insurance) will be assessed a $25 billing charge. An additional $75.00 minimum amount will be charged if outside collection agency and/or small claims court are required to collect the balance on an account. I agree to resolve all financial matters with ACC on my own, without legal representation.

Chiropractic, like medicine, is an applied science as well as an art; absolute guarantees are not possible. I understand that regardless of individual results, I am responsible for payment for services received at ACC. If I suspend or terminate my recommended treatment of care, any fees for professional services will be immediately due and payable. ***There is a 0.0399% surcharge for using credit/debit cards.***

Health Insurance Portability and Accountability Act (HIPAA): ACC's current Notice of Privacy Practices (NOPP) has been made available to me. The NOPP explains my rights and ACC's duties regarding my PHI, including ways in which my PHI may be used or disclosed by ACC. ACC reserves the right to amend its NOPP. A printed copy of ACC's current NOPP is provided upon request at ACC's main administrative desk, or by calling ACC and asking that a copy be mailed to me.

These people are authorized to receive my health and financial information:

Name: _____Relationship: _____Phone: _____

Name: _____Relationship: _____Phone: _____

I understand and agree to all the above financial responsibility/HIPAA terms and conditions:

Patient/Guardian Signature: _____Date: _____Witness: _____

Patient/Guardian Signature: _____Date: _____Witness_____

Patient/Guardian Signature: _____Date: _____Witness: _____