CONFIDENTIAL PATIENT INFORMATION FORM **DATE: / / 2020**

(PLEASE READ CAREFULLY, FILL IN ALL BLANKS, INITIAL WHERE INDICATED AND SIGN AND DATE BOTTOM OF FORM)

PATIENT INFORMATION

Full Name: ______________________________ Date of Birth: ______/______/______ Age: ________ ☐ Male ☐ Female

Address: ____ Apt#: ________ SSN: ________-________-________

City: ________________________ State: ________ Zip Code: __________ Home Phone: (______) ______________

Cell Phone: (________) __________________ Email Address: _______________________@______________.com

Marital Status: ☐ Single ☐ Married ☐ Widowed Patient Resides with: ☐ Alone ☐ Spouse ☐ Parents ☐ Children ☐ Other: ________

# of Children: ______ Date Symptoms Began: ______/______/______ How/When did the pain begin? ____________________

Emergency Contact: __________________________ Relationship: ______________ Phone (______) ______________

How did you hear about our office? ☐ Google ☐ Internet ☐ Facebook ☐ Drive by ☐ Other: ________________________

Employer's Name: ______________________ Occupation: ____________ Work Phone (______) __________ Ext. ______

Work Address ________________________ City______________ State ________ Zip____________ ☐ Full time ☐ Part time

Is Your Condition Due To: ☐Auto Accident ☐Personal Injury ☐Work Injury ☐Other: ____________ Date of Injury/illness: __________

Type of Claim: ☐ Self pay ☐ Health Insurance ☐ Personal Injury ☐ Worker's Comp ☐ Medicare ☐ Medicaid ☐ Attorney/PIP

AUTHORIZATIONS

A. Initial: _______ I consent to treatment necessary to my care.

B. Initial: _______ I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

C. Initial: _______ I authorize payment of any medical benefit from third parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by any attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

D. Initial: _______ I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

E. Initial: _______ Our office, physicians and staff, are committed to securing the privacy of your health information. We are making available to you a copy of our Notice of Privacy Policies at your request.

F. Initial: _______ I hereby authorize and request that payment of benefits by my primary insurance company and my secondary insurance (if any) be made directly to Adrian Chiropractic for services furnished to me or my dependent. I understand that my insurance company will only cover contracted services. I further understand that I am responsible for all charges not covered by this assignment, this excludes all contractual discounts/adjustments.

G. ***Consent to treatment of a minor (If applicable).*** If there are any circumstances when I am unable to bring my child to the office for his/her evaluation and treatment, I give permission and authorization to Adrian Chiropractic and its physicians and staff to administer examination and medical treatment as deemed necessary to him/her. **Parent or Guardian Initial here:** __________

H. Release of Information to **other** party/family member: I authorize Adrian Chiropractic and its physicians and staff to use the following ***additional contact*** listed below to discuss or disclose information regarding any matters relating to my appointments, billing information and/or medical care. You may release any of the information above to the following person:
Name: ________________________ Relationship: __________________ Phone: ______________

APPOINTMENTS

Our office has a reminder system to send you appointment and special event reminders via email and/or text message for your convenience. If you wish to decline being sent any future texts and/or e-mails, please make the front desk aware and check the box below.

☐ I decline being sent text or e-mail messages about my appointments.

Initial: _______ We would like to thank you in advance for keeping your scheduled appointments and notifying our office of any changes. **Please be aware there is a $20 missed appointment fee.** Please give us a call **24 hours before your appointment** to cancel or reschedule to avoid this fee.

SIGNATURE

I fully understand and agree to all the Authorization statements stated above.

Patient or Parent/Guardian Signature: ____________________________ **Date:** ________________

If Parent/Guardian Print Name: ________________________________ **Relationship:** ____________