PATIENT UPDATE INFORMATION FORM

Date_____
Name_____ Soc. Sec. #____-____-____ Birth Date___/___/___
Address_____ City_____ State___ Zip_____
Home Phone (____) ____-_____ Cell phone (___) ____-_____ Marital Status **M S W D**
Occupation _____ Name of employer_____
Employer Address_____ City _____
State ____ Zip _____ Employer Phone (____) _____-_____
In case of an emergency contact_____ Relationship _____
Contact Phone #_____ Alternate contact # _____
What has brought you here today? _____
Date symptoms began _____
Have you had any accidents/trauma/big falls since your last treatment? Y N If yes, when _____

Please present current insurance card at the window.

Name of primary insured _____SS#____-__-____DOB__/__/___

Please remember that your medical insurance is a contract between you and your insurance company and any questions regarding coverage should be directed to your insurance company.

READ AND SIGN THE FOLLOWING

I understand and agree that the health and accident insurance policies are an arrangement between the insurance company and me. I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment.

I also understand and agree that if I suspend or terminate my care, any fees for professional services rendered to me will be immediately due and payable.

I also understand that I will be held responsible for all cost of collection including attorney fees, collection fees, and contingent fees to collection agencies of not less than 35%, such contingency fees to be added and collected by the collection agency immediately upon your default and our referral of your account to said collection agency.

I will also be responsible for 1.75% monthly interest on unpaid balance.

I authorize any third party payment due myself or any representative to be made directly to this clinic or Doctor. I hereby authorize the Doctor to treat my condition as she seems appropriate through the use of manipulation throughout my spine. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

I authorize you to release to my insurance company information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering benefits of claims.

Patient Signature_____ Date____/__/____

Authorized Guardian _____Date ___/__/___