CONFIDENTIAL PATIENT INFORMATION FORM

DATE: / / 2022

(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: _____

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 at the time of service. 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. If payment is not received in a timely matter, I am aware my personal information and any open balances will be forwarded to a collections company if my account becomes delinquent. Please be advised payment arrangements are always available for your convenience.

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.

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: _____

APPOINTMENT

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:** _____