

Welcome to Our Practice...

Acton Chiropractic & Rehabilitation, Inc.

Patient Information

Date: _____
SS #: _____
Patient Name: _____
Last Name
First Name Middle Initial
Address: _____
City: _____
State: _____ Zip: _____
E-Mail: _____
Would you like to receive Dr. Joe's e-newsletter? Yes No
Sex: M F Age: _____ Height: _____ Weight: _____
Birthdate: _____
 Married Widowed Single Minor
 Separated Divorced Partnered for _____ years.
Occupation: _____
Employer: _____
Employer Address: _____
Employer Phone: (____) _____
Spouse's Name: _____
Birthdate: _____
SS#: _____
Spouse's Employer: _____
How were you referred to our office? _____

Phone Numbers

Home (____) _____
Cell (____) _____
Work (____) _____
Best time and place to reach you: _____

IN CASE OF EMERGENCY CONTACT:

Name: _____
Relationship: _____
Home (____) _____
Cell (____) _____

Accident Information

Is this condition due to an accident? Yes No
Date: _____
Type: Auto Work Personal Injury Other
To whom have you made a report of your accident?
 Auto Ins. Employer Worker Comp Other
Attorney Name: _____

Insurance

Insured's Name: _____
Relationship to patient: _____
Insurance Co.: _____
ID#: _____ Group #: _____
Insured's Birthdate: _____
Is patient covered by additional ins.? Yes No
Insurance Co.: _____
Insured's Name: _____
Insured's Birthdate: _____
Relationship to patient: _____
ID#: _____ Group #: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Acton Chiropractic and Rehabilitation, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

You must stay current with your amount of responsibility as you receive treatment. **Co-Payments are paid at each visit** or you may pay ahead for later treatments. All patients are responsible for payment of any **deductible, co-insurance and non-covered services** that are incurred at this clinic. A non-covered service is defined as a service not covered by your insurance. If you do not have insurance coverage, payment is due when services are rendered. Fees are subject to change without notice.

A complete list of fees and our X-Ray policy is located on the bulletin board in the main hallway. We require payment for all supplies at the time they are issued. A copy of this signed policy will be provided upon your request.

Please sign below that you have read and understand the above policies. It is further understood that you are aware that you are ultimately and fully responsible for payment of the services you incur at this clinic.

Patient Name Printed: _____
Signature of Patient or Guardian: _____ Date: _____
Relationship to Patient: _____

