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: _____