

Welcome

Patient Information

Date _____

Patient Name _____
 Last Name _____
 First Name _____ Middle Initial _____

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex M F Age _____

Social Security # _____

Birthdate _____

Married Widowed Single Minor
 Separated Divorced Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

Home Phone (_____) _____

Cell Phone (_____) _____

Work Phone (_____) _____

Best time and place to reach you _____
IN CASE OF EMERGENCY, CONTACT

Name _____ Phone _____

Spouse's Name _____

Birthdate _____

Spouse's Employer _____

How did you hear about our office? _____

Accident Information

Is condition due to an accident? Yes No

Date _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?
 Auto Insurance Employer Worker Comp. Other

Attorney Name (if applicable) _____

Insurance

Health Insurance Name _____

Who is the primary insured? _____

Relationship to Patient _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS # _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

FINANCIAL RESPONSIBILITY

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Kurtz Chiropractic Clinic and/or its affiliated entities for any charges not covered by health care benefits. It is my responsibility to notify Kurtz Chiropractic Clinic of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Kurtz Chiropractic Clinic and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

ASSIGNMENT OF BENEFITS

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Kurtz Chiropractic Clinic for all covered medical services and supplies provided to me during all courses of treatment and care provided by Kurtz Chiropractic Clinic and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by Kurtz Chiropractic Clinic, and will constitute a continuing authorization, maintained on file with Kurtz Chiropractic Clinic, which will authorize and allow for direct payment to Kurtz Chiropractic Clinic of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by Kurtz Chiropractic Clinic.

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. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date

Relationship to Patient