CenterPoint Chiropractic
Yearly Demographic Update

Name (First)________________________________ (MI) __________ (Last) _________________________________

Street Address ____

City ____ State ____________________ Zip ____________________

Home Phone ______________________________ May we leave a message at this number? ▫ Yes ▫ No

Work Phone ______________________________ May we leave a message at this number? ▫ Yes ▫ No

Cell Phone ________________________________ May we leave a message at this number? ▫ Yes ▫ No

Email Address ____ Opt Out of Email ▫

Gender: ▫ Female ▫ Male Marital Status: ▫ Single ▫ Married ▫ Separated ▫ Divorced ▫ Widowed

Date of Birth _________________________________ Social Security Number _________________________________

Employment Status: ▫ Employed ▫ Unemployed ▫ Retired ▫ Part-Time Student ▫ Full-Time Student

CONSENT TO TREAT: I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity. ________ (patient initials)

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment of medical benefits furnished to me by the chiropractor(s) of CenterPoint Chiropractic. I understand I am financially responsible for any amount (1) not covered by my insurance company, HMO, POS or PPO and (2) if my insurance company requires a referral and I have not obtained the referral prior to services being rendered. I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive. ________ (patient initials)

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize CenterPoint Chiropractic to release any information acquired in the course of my examination and/or treatment to: (1) my insurance company(ies), (2) to any physician who has referred me for treatment, and (3) to any physician to whom I may subsequently be referred. ________ (patient initials)

CONTACT RELEASE INFORMATION: I agree to permit CenterPoint Chiropractic and their business associates to contact me, and all other responsible parties on my account, on our cell phone or other mobile device concerning any and all aspects of my account: financial, procedural or scheduling. I also give permission to be sent occasional cards, letters, emails, or health information to me as an extension of my care in this office. ________ (patient initials)

PRIVACY POLICY: I realize that I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties. ________ (patient initials)

NO CALL/NO SHOW POLICY: We require a cancellation/reschedule notice within 3 hours of appointment time. Please be advised that there will be a $50 fee for missed appointments with less than a 3 hour notice. _______ (patient initials)

To the best of my ability, the information I have supplied is complete and truthful. I attest that I have read and understand the policies of CenterPoint Chiropractic, and accept my responsibility as stated in those policies. ________ (patient initials)

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. ________ (patient initials)

Please List the names of anyone that you give permission to access your personal health information on the lines below. This includes personal health information including, but not limited to all appointment information, test results etc. We will not disclose any of your personal health information to anyone that is not listed below.
Name____ Relationship ______________________________ Phone Number ___________________________________
Name____ Relationship ______________________________ Phone Number ___________________________________
Name____ Relationship ______________________________ Phone Number ___________________________________

Patient Signature: ____ Date ______________________________

17 years of age and under required signature of Parent/Guardian/Responsible Party

(OVER)

CenterPoint Chiropractic
Yearly Demographic Update

Financial Policy, Patient Bill of Rights and Responsibilities

Thank you for choosing CenterPoint Chiropractic as your healthcare provider. We are committed to providing excellent healthcare services to you, our patients. As a part of our professional relationship, it is important that you have an understanding of our financial policy. All patients must read and sign this form prior to receiving services. It is your responsibility to provide us with your most current insurance information.

1. If you do not have health insurance, or your health insurance does not have chiropractic benefits, you are financially responsible for the full amount of services rendered.

2. We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company, and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.

3. If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for the full amount of services rendered.

4. Please be aware that some or perhaps all of the services may not be covered in full by your insurance company. You are financially responsible for services not covered by your insurance company.

5. Before receiving services, you should verify that we are participating providers for your insurance company. It is also necessary that if you are a participant in an HMO plan you must obtain an insurance referral from your primary care physician listed on your insurance card before you are seen by another healthcare provider.

6. Co-payments must be collected at the time of service. This is a requirement set by your insurance company. No exceptions.

7. You must provide your most current billing address, all available telephone numbers and any other important contact information and if any of this changes, it is your responsibility to contact us with the updated information.

8. Billing and/or finance fees will be added to any patient balance greater than 30 days past due.

9. Personal Injury or Automobile Accidents: It is our office policy to allow 90 days after you have been dismissed from care for the claim to be settled with the liability company. Once the 90 days is reached, if no settlement has been made, we require the patient to start making payments towards their personal injury case.

By signing below you acknowledge that you have read the Financial Policy and fully understand its terms.

Patient/Responsible Party Signature ____

Print Patient Name ________________________________DOB_______________ Date: _________________