NEW PATIENT INFORMATION

Name: _____ (Age)_____ Gender: M F
Home Address:_____ Home Phone( )_____
City, State, Zip: _____ Work Phone ( )_____
Email Adress:_____ Cell Phone ( )_____
Birth Date____/____/_____ Social Security#_____-_____-_____ Marital Status S M D W
Occupation:_____ Employer Name:_____
Spouse's Name:_____ Work Phone ( )_____ Cell Phone: ( )_____
Spouse's Employer:_____ Occupation:_____
How were you referred to this office? _____

PURPOSE OF THIS VISIT

Reason for this visit-Main Complaint:_____
Is this purpose related to an auto accident/work injury? Yes ___ No ____ If so, when:_____
When did this condition begin:_____/_____/_____ Did it begin: Gradual Sudden Progressive over time
What activities aggravate your symptoms?_____
Is there anything that has relieved your symptoms?_____
Type of Pain: Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting
Does the pain radiate into your: Arm___ Leg___ Does not radiate___
How often do you experience these symptoms throughout the day? 100% 75% 50% 25% 10% Only with activity
Does the complaint(s) interfere with: Work___ Sleep___ Hobbies___ Daily Routine Explain:_____
Have you ever experienced this condition before? Yes ___ No ___
If so, please explain:_____
Who have you seen for this?_____ What did you do?_____
How did you respond?_____

Is there any chance of pregnancy? Yes ___ No ___
Date of last menstrual period: _____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? Yes ___ No ___ Who?_____ When?_____
Reason for visits:_____
How did you respond:_____

This office conforms to the current HIPPA guidelines. You may request a copy of our HIPPA policy at the front desk. Please initial to indicate you have been made aware of its availability: Initials:_____

The statements made on this for are accurate to the best of my knowledge and I agree to allow this office to examine me for further evaluation.

Patient Signature:_____ Date_____
Guardian Signature:_____ Date_____

Marsh Chiropractic & Wellness Center

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR FROM PRIVATE AND GROUP HEALTH INSURANCE, ACCIDENT, AND AUTOMOBILE INSURANCE

I hereby authorize and instruct any insurance company from which payment may be forthcoming to cover any services rendered at this office, (including but not limited to chiropractic adjustments, therapy, exams, x-rays, supplements) to make direct payment to Marsh Chiropractic for any medical benefits for any and all treatment in a timely manner. If my current policy prohibits direct payment to doctor, then I hereby instruct and direct you to make the check payable to myself and Marsh Chiropractic; at which time, I appoint Marsh Chiropractic & Wellness Center as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft in which I am named payable and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with Marsh Chiropractic & Wellness Center.

I authorize the release of any medical or other information necessary to process any claim for reimbursement of charges incurred to any insurance company, adjuster, or attorney involved in this case. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional services charged over and above this insurance payment. I further agree that this authorization and release is irrevocable and ongoing until all monies owed are paid in full; either upon conclusion of services, or in accordance with any signed agreement/payment plan. This authorization and release will be in continual effect until revoked by both parties. I have read the above information and I understand my insurance benefits. I also understand that this is not a guarantee of payment of claims. I understand all services rendered to me are ultimately my financial responsibility, and I am obligated to pay for all usual and customary benefits denied by my insurance carrier. A photocopy of this assignment shall be considered as effective and valid as this original.

Under my health plan, I am financially responsible for co-payments, co-insurance and/or deductibles for covered services. I am also financially responsible for all non-covered services, including care determined by my insurance company or plan to be elective, wellness, chronic, or maintenance. Elective, wellness, chronic or maintenance care are treatments that do not significantly improve a clinical condition. While being treated for a chronic condition, I may elect to receive care beyond that which is determined to be medically necessary. I may also choose to receive wellness or maintenance care once maximum therapeutic benefits from treatments have been reached. If, during the course of these types of care, I develop a new condition or a previous condition becomes significantly worse, care may no longer be considered maintenance/elective and may then be covered by my health plan. I agree to be personally responsible for any and all fees involved in the collection of any overdue account. I also understand there is a $25 billing fee for each and every billing attempt made by Marsh Chiropractic.

If you are unable to keep a scheduled appointment, please give notice at your earliest convenience. If notice is not given before your appointment time, we reserve the right to charge a $40.00 missed appointment fee.

I acknowledge that I have been told in advance by my provider or his/her staff that the services listed above may not be covered by my health plan. If these types of care fall under my plan's definition of non-covered care for any reason, I agree to pay for these services. This agreement is irrevocable by anyone other than Marsh Chiropractic until all outstanding balances are paid in full.

Signature_____ Date: _____