CORE Chiropractic

Name: _____ Today's Date: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Work Phone: _____

Email: _____ SS#: _____

Date of Birth: _____ Age: _____ Sex: ☐ M ☐ F ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Other Name of Spouse: _____

Occupation: _____ Company: _____

How did you hear about our office? _____

Please describe your current problem: _____

_____

Please list any surgeries you've had and the approximate date: _____

_____

Please list any medications you're taking: ☐ No medications

Have you been treated by a physician in the last year? ☐ Yes ☐ No

If yes, list condition: _____

Please check any conditions you've had in the past or now have:

☐ Yes	☐ No	Headaches or neck pain	_____
☐ Yes	☐ No	Shoulder pain or arm pain	_____
☐ Yes	☐ No	Upper or mid back pain	_____
☐ Yes	☐ No	Chest pain/ lung problems	_____
☐ Yes	☐ No	Heart problems	_____
☐ Yes	☐ No	Liver / kidney / bladder	_____
☐ Yes	☐ No	Stomach or digestion	_____
☐ Yes	☐ No	Colon or constipation	_____
☐ Yes	☐ No	Low back pain	_____
☐ Yes	☐ No	Hip or leg pain	_____

I certify the above information to be correct to the best of my knowledge. I also understand that I am financially responsible for all charges, but that I will be informed of any charged services before they are performed.

Patient (*Parent or Guardian*) Signature Date

CONSENT TO RELEASE INFORMATION

I understand the Notice of Privacy Practices is available for my review. This provides a complete description of my health information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that CORE Chiropractic reserves the right to change their notice and practices. I understand that I may revoke this consent in writing, except to the extent that CORE Chiropractic has already taken action in reliance thereon. I consent to the use and disclosure of my health information for treatment, payment, and healthcare procedures as described in the Notice of Privacy Practices.

Patient (*Parent or Guardian*) Signature Date

CONSENT TO TREAT MINOR CHILD

I hereby authorize CORE Chiropractic and its providers and staff to administer physical examination, radiographic examinations, and treatment as it deems necessary to the patient listed at the top of this page. I am legally authorized to sign this consent.

Patient (*Parent or Guardian*) Signature Date

CONSENT TO X-RAY/VERIFICATION OF NON-PREGNANCY

I do hereby state that, to the best of my knowledge, I am not pregnant. I also state that pregnancy is neither suspected nor confirmed at this time. I do hereby release CORE Chiropractic from any liability and authorize them to complete any x-ray examination they deem necessary.

Patient (*Parent or Guardian*) Signature Date

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize and direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals and/or other legal entities (“payers”), which may elect or be obligated to pay, provide or distribute proceeds to me for any medical conditions, accidents, or injuries, or illnesses, past, present, or future, (“condition”) to pay directly and exclusively in the name of CORE Chiropractic (“office”) such sums as may be owed said offices for charges incurred by me at the office relating to my condition (“charges”), with such payment to be made exclusively in the name of CORE Chiropractic.

For the purposes of this document herein (“assignment”), “proceeds” shall include, but not be limited to, monies/proceeds from any settlement, judgment, or verdict, as well as any monies/proceeds relating to commercial health or group insurance, attorney retainer agreements, medical payments benefits, personal injury protection, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, disability benefits, worker’s compensation benefits, and any other benefits or proceeds payable to me for the purposes stated herein.

I authorize this office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this assignment. I further authorize and direct all payers to release to office any information regarding my coverage or benefits which I may have including, but not limited to, the amount of coverage, the amount paid thus far, and the amount of any outstanding claims. I hereby direct this office to file a copy of this assignment, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize CORE Chiropractic to endorse/sign my name on any and all checks listing me as payee, which are presented to this office for payment of any account relating to me, my spouse, or any of my dependents.

I also understand and acknowledge that I am financially responsible for non-covered services and any unpaid insurance balance over 45 days past due. Payments, co-pays, and deductibles are due at the time of service unless a payment plan is in effect. I understand that not all services and products may be covered by my insurance or may exceed benefits of coverage. Insurance quotes are not a guarantee of payment. If the insurance representative quoted us incorrect information, they are not held responsible and therefore the fee will reflect what your benefits are for the date of service in the order it was processed.

Patient (*Parent or Guardian*) Signature Date