

OFFICE INFORMATION

If you are treating for a car or work injury, please let our receptionist know so we may provide you with the appropriate paperwork.

Name: _____ Date: _____

Address: _____ E-mail: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Sex: M F Age: _____ Birthdate: _____

Employer/School: _____ Occupation: _____

Phone: _____ Whom may we thank for referring you? _____

Spouse Name: _____ Spouse Employer: _____

Have you had chiropractic care before? YES NO If yes, where: _____

Students must provide permanent home Address: _____

Phone: _____

Please read thoroughly, initial at each section and sign at the bottom. Thank you

CONSENT FOR TREATMENT

_____ I, the undersigned, a patient in this office hereby authorize Dan Hafner, Diane Barry (and whomever they may designate as their assistant(s) to administer treatment as is necessary.

I also certify that no guarantee or assurance has been made as to the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and myself. Furthermore, I understand that this office will prepare any necessary forms and reports to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse my remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

_____ I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

REQUEST FOR PAYMENT OF BENEFITS TO PROVIDER OF CARE

_____ I hereby authorize the _____ Insurance Company/Insurance Administrator to pay by check and for it to be mailed directly to Complete Chiropractic Health Services, P.A. for the expense benefits allowable, and otherwise payable to me under my current policy, as payment toward the total charges for the professional services rendered, and I have agreed to pay, in a current manner, any balance of said professional charges. I agree that this office be given power to attorney to endorse/sign my name on any and all drafts for payment of my bill.

CONSENT FOR TREATMENT OF A MINOR

_____ I hereby authorize Dr. Dan Hafner, Dr. Diane Barry or whomever they may designate as their assistant(s) to administer chiropractic care as they deem necessary to my _____ (indicate relationship of the child).

Signature of Patient or Responsible Party

Date

FINANCIAL POLICY

Complete Chiropractic Health Services will process any and all insurance claims on behalf of our patients. Since it is impossible for us to keep track of every insurance plan and how it works, we expect you to know your own coverage for **chiropractic services**. If you have questions regarding your plan coverage, copays, deductible, or coverage of supplies, please contact your insurance company referencing **chiropractic benefits** before beginning treatment. We are not responsible for determining whether your insurance will cover services rendered.

NO INSURANCE: If you do not have insurance coverage for chiropractic, we require payment at the time of service. You may contact our Business Office at (651) 690-9366 to discuss payment arrangements if necessary.

INSURANCE: We will process any and all insurance claims on behalf of our patients. In order to provide this service, all insurance information and a copy of your insurance card must be provided to our office on your first visit. Assignment of benefits is also required with commercial insurance. Failure to provide complete insurance information will result in the account being billed directly to the patient.

CO-PAYMENTS AND REFERRALS: Co-payments required by your insurance plan are collected at the time of service. If an insurance referral from your primary physician is required, you are responsible for verifying it is in their system at the time they process your claim. If you choose to be seen without the appropriate referral, you agree to be responsible for the charges should they not be covered by your insurance.

SUPPLIES: We require payment for supplies when they are issued. We will submit all supply charges to your insurance and will reimburse you should they pay. If your insurance company denies payment, you are personally and fully responsible for payment.

WORKERS COMPENSATION / AUTO ACCIDENTS: We will file both Workers Compensation and Auto claims on your behalf. We will need the following information in order to do so: the name, address, and phone number for your employer / insurance carrier, and the date of injury and the claim number.

COBRA INSURANCE: You are responsible to provide all COBRA insurance information and to notify the billing office when your COBRA is activated to avoid denial of your claims by your insurance.

DISPUTES: If for any reason your insurance claim goes into litigation, you are responsible to work closely with your attorney and remain involved in your case. Failure to do so will result in us requiring monthly payments for your treatments until your balance is zero.

I acknowledge that I have read and understand all of the foregoing and I accept the financial policy of Complete Chiropractic Health Services. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

PATIENT SIGNATURE: _____ **DATE:** _____

WITNESS SIGNATURE: _____ **DATE:** _____

IF PATIENT REFUSES TO SIGN THIS STATEMENT BUT CONTINUES TO RECEIVE TREATMENT, COMPLETE CHIROPRACTIC HEALTH SERVICES WILL REGARD THIS AS THE PATIENT'S ACCEPTANCE OF THE ABOVE POLICIES.