Patient First
Chiropractic & Physical Therapy
For quick, effective recovery from tough pain and injury

Patient Information

Today's Date	☐ Auto ☐ Worker's Comp ☐ Other	Area to be Treated
Last Name	First Name, Middle Initial	
Street Address	Town	State / Zip Code
Home Phone	Work Phone / Cell Phone / Email	
Date of Birth	Gender ☐ Male ☐ Female	Marital Status ☐ Married ☐ Single ☐ Divorced
Please remind me of appointments by: Email : _____		Please send me your newsletter ☐ Yes ☐ No
Emergency Contact Name:	Phone	Relationship to Patient
Employer		Occupation
Employer Street Address	Town	State / Zip
Primary Care Physician Name	Phone #	Have You Had Physical Therapy Before? ☐ Yes ☐ No
Referring Physician Name	Phone #	If yes, when:
Primary Health Insurance Carrier	Member ID#	Group #
Primary Insured Name	Insured Date of Birth	Relationship to Patient
Address (if different from patient)		Insured Phone #
Secondary Health Insurance Carrier (if applicable)	Member ID#	Group #
Primary Insured Name	Insured Date of Birth	Relationship to Patient
Address (if different from patient)		Insured Phone #
Worker's Comp/Auto Information (if applicable) Insured Name	Adjuster Name	Claim#
Insurance Address and Phone #		Date of Injury
Attorney Name, Address and Phone #		
Are you currently, or have you recently had home health services? ☐ Yes ☐ No	If yes are you still receiving service? ☐ Yes ☐ No If no, when were you discharged?	
Have you received physical therapy/chiropractic treatment for your current or any other condition within the last 12 months? ☐ Yes ☐ No If yes, when _____		
How did you hear about us?		

CONSENT TO TREATMENT

I hereby authorize the professional staff at Patient First Chiropractic and Physical Therapy to examine and treat me with chiropractic/physical therapy for the injury I have been referred here for or referred myself to.

_____	_____
Patient Signature	**Date**
_____	_____
Patient Printed Name	**Staff Witness Signature**
_____	_____
Parent or Guardian Signature (if under 18)	**Date**
_____	_____
Parent or Guardian Printed Name	**Staff Witness Signature**

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO HEALTH PROVIDER

Insurance Company/Companies Name(s) _____

I hereby instruct the above named insurance company/companies to pay by check made out to and mailed directly to: Patient First Chiropractic and Physical Therapy for professional or medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. 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 fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy.

_____	_____
Patient Signature	**Date**
_____	_____
Patient Printed Name	**Staff Witness Signature**
_____	_____
Parent or Guardian Signature (if under 18)	**Date**
_____	_____
Parent or Guardian Printed Name	**Staff Witness Signature**

HIPAA REGULATIONS

I understand that Patient First Chiropractic and Physical Therapy complies with HIPAA and will protect my Protected Health Information (PHI) and will use it as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed and full payment is received. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney for the purpose of securing payment under this policy of insurance or to any Medical Provider associated with my case to effectively treat me. The authorization is in effect until 90 days from the date the last bill is collected.

I have received a copy of the Notice of Information Practices. A photocopy of this Assignment shall be considered effective and valid as the original.

_____	_____
Patient Signature	**Date**
_____	_____
Patient Printed Name	**Staff Witness Signature**
_____	_____
Parent or Guardian Signature (if under 18)	**Date**
_____	_____
Parent or Guardian Printed Name	**Staff Witness Signature**