

Patient First

Chiropractic & Physical Therapy

For quick, effective recovery from tough pain and injury

Patient Information

Today's Date	<input type="checkbox"/> Auto <input type="checkbox"/> Worker's Comp <input type="checkbox"/> Other	Area to be Treated	
Last Name		First Name, Middle Initial	
Street Address		City/Town	State Zip Code
Home Phone	Work Phone	Cell Phone	
Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced	
Appointment Reminders: <input type="checkbox"/>			
Email:			
Emergency Contact Name:		Phone	Relationship to Patient
Primary Care Physician Name		Phone #	Have You Had Physical Therapy Before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when:
Referring Physician Name		Phone #	
Primary Health Insurance Carrier		Member ID#	Group #
Subscriber's Name		Subscriber's Date of Birth	Relationship to Patient
Address (if different from patient)			Subscriber's Phone #
Secondary Health Insurance Carrier (if applicable)		Member ID#	Group #
Are you currently, or have you recently had home health services? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes are you still receiving service? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when _____			

How did you hear about us?

Please fill out back side →

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