About Life chiropractic

8878 South Street, Fishers, IN 46038

DEMOGRAPHICS AND ASSIGNMENT OF BENEFITS

Today's Date: ____/____/____
(MM/DD/YYYY)

CONFIDENTIAL HEATH INFORMATION

WHOM MAY WE THANK FOR REFERRING YOU?			
YOUR LAST NAME	YOUR SOCIAL SECURITY NUMBER		GENDER O Male O Female
YOUR FIRST NAME	YOUR MIDDLE NAME (OR INITIAL)	BIRTH DATE (MM/DD/YYYY)	
ADDRESS			HEIGHT
CITY	STATE	ZIP/POSTAL CODE	WEIGHT
HOME PHONE	CELL PHONE	MARITAL STATUS O Single O Married O Divorced O Widow O Separated	
E-MAIL ADDRESS		SPOUSE'S NAME	
EMERGENCY CONTACT		PHONE	
YOUR OCCUPATION		YOUR EMPLOYER	
PRIMARY PHYSICIAN			

ACKNOWLEDGEMENTS

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

_____ INITIALS — I have read and reviewed the Privary Policy and understand it describes how many personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

_____ INITIALS — I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in the office.

_____ INITIALS — I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

_____ INITIALS — I may request a copy of the Financial Policy at any time.

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

_____
Signature

_____
Date (MM/DD/YYYY)

_____
If the patient is a minor child, print child's full name

ASSIGNMENT OF BENEFITS

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered, assigns to the physician or facility named above the following rights, power, and authority.

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney, or insurance adjuster, for the purpose of processing my claim for benefits and payment of service rendered to me.

IRREVOCABLE ASSIGNMENTS OF RIGHTS: You are assigned the exclusive irrevocable right to any cause of action that exists in my favor against any insurance company for benefits to the extent of your bill for total services if such benefits are owed within the terms of policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court costs, or other legally compassable amounts owed by an insurance or state statute. I, as the patient and/or the responsible party, further agree to cooperate and provide information as needed, and appear as needed wherever, to assist in prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above, you are hereby tendered demand for pay in full the bill for services rendered by the physician/facility named above within 60 days following your receipt of such bill for services to the extent such bills are payable under the terms of my/our policy for the benefits, less any amounts which I/we owe personally which are not payable under the terms of your policy. In consideration of the services to be provided to the patient, I/we hereby guarantee payment in full of the patient's account in accordance with the financial arrangements made at the time of discharge or, if no such arrangements are made, then payment shall be made in full within thirty (30) days of discharge. I/we agree that in event of default in payment, reasonable collection agency fees equal to fifty (50%) percent of the delinquent balance and reasonable attorney fees, shall be added to the amount due on the account, plus any applicable court costs.

THIRD PARTY LIABILITY: If patient(s)' treatments for injuries are the result of the negligence of any third party, then patient(s) grant a lien and assignment of cause of action against any right of recovery from such third party(s) to the extent of the bills of treatment, in favor of the physician/facility named above.

INSURANCE AGREEMENT: I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare my necessary reports and forms to assist me in making collection from the insurance company, and that any amount authorized to be paid directly to co-issued 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. This demand specifically conforms with this state's insurance code, providing for attorney fees, penalty, court costs, and interest from judgment, upon violation. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

A photocopy of this instrument shall serve as original.