Chiropractic Healthcare Associates

Patient Information

Account number:_____

Name _____ Date of Birth _____
Address _____
City _____ State _____ Zip code _____
Social security Number _____ Male ☐ Female ☐
Home phone number _____ Martial Status M S W D
Cell number _____ Email _____

Occupation _____ Employer _____ Work phone _____
Address _____ City _____ State _____ Zip code _____

Who referred you to our office? _____

Primary Care Physician _____ Phone _____
Address _____ Permission to Contact Yes ☐ NO ☐

Health insurance Please present cards for copying
Primary insurance _____ **Subscriber is same as patient** Yes ☐ No ☐
Subscriber's name _____ Date of birth _____
Id number _____ Group number _____
Secondary insurance _____
Subscriber's name _____ Date of birth _____
Id number _____ Group number _____
If auto accident: Auto insurance card (copy need) include Health Insurance
Auto Insurance Name _____ Phone Number _____
Attorney name _____ Phone number _____
Address _____ City _____ State _____ Zip code _____
Claim Number _____ Adjuster's name _____

Please read and sign the following:

Consent to Treat:
I the undersigned, herby authorize the Doctors of Chiropractic Health Care Associates and whomever they may designate as their assistants to perform diagnostic tests including but not limited to radiographs, and to administer treatment as is necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that my amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse 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 and release: I authorize payment of insurance benefits directly to Chiropractic Healthcare Associates. I authorize Chiropractic Healthcare Associates to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of case as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow Chiropractic Healthcare Associates to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know that your Patient Health Information is going to be used by this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to ready the HIPAA Privacy Notice that is available to you at the front desk before signing this consent. If there is anyone that you do not want to receive your medical records, please inform our office.

Patient's Signature _____Date_____

Guardian's Signature Authorizing Care _____Date_____