

Patient Information

Full Name _____ Date of Birth _____ Gender: M F

Address _____ City/State _____ Zip _____

Home Phone _____ Work _____ Cell _____

Social Security Number _____ - _____ - _____ Student? Yes No

E-mail address _____

Your Employer (or School) _____ Your Occupation _____

Employer Address _____

Married Single Widow (er) Divorced Seperated

If Married: Spouse Name: _____ Spouse Date of Birth _____

Spouse Employer _____ Spouse Occupation _____

INSURANCE INFORMATION (please allow our staff to photocopy your insurance card and photo ID)

Do you have insurance? Yes No Primary Insurance _____ Secondary _____

Are you the policy holder? _____ If no, name of policy holder _____

Date of Birth of policy holder _____ Relationship to holder _____

I hereby instruct and direct any and all insurance companies, lawyers, or employers liable for my health care benefits to pay by check made out and mailed to:

First Choice Chiropractic •

OR: If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

c/o First Choice Chiropractic •

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the 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 service charges over and above this insurance payment.

I hereby authorize and direct you, my insurance carrier, to pay directly to First Choice Chiropractic such sums as may be due and owing this office for services rendered me, both by reason of accident or illness and by reason of any other bills that are due this office and withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident, Workers' Compensation benefits, or any other insurance benefits obligated to reimburse me from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect First Choice Chiropractic. I hereby further give lien to said office against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the office's services provided.

I understand that I remain personally responsible for the total amounts due to the offices for services rendered. I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for the office to await payments, and they may demand payments from me immediately upon rendering services at their option. **A photo of this Assignment shall be considered as effective and valid as the original.**

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case to facilitate collection under this Assignment, Lien and Authorization.

I understand I am ultimately responsible for payment to this office. If for any reason my insurance company should pay me for services received in this office instead of paying directly to First Choice Chiropractic, I understand that payment is for services performed here, and I must bring the payment in immediately upon receipt.

I have read and understand the foregoing.

Patient's Signature _____
(Authorization expires three years from date above)

Date _____

How did you hear about us? _____