

**Patient Information** required

Full Name: \_\_\_\_\_

I prefer to be called : \_\_\_\_\_

Age : \_\_\_\_\_ Birthdate : \_\_\_\_\_

Social Security # : \_\_\_\_\_

Address : \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone 1: \_\_\_\_\_

Work/ Daytime Phone 2: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Work Address (city) : \_\_\_\_\_

Bank (name & city) : \_\_\_\_\_

**Family Status:** Single Married Divorced Widowed

If married:

Spouse name: \_\_\_\_\_

Work/ Daytime phone: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

**Worker's Compensation** (if applicable):

Name of Employer : \_\_\_\_\_

Claim # : \_\_\_\_\_

WC Administrator : \_\_\_\_\_

Address : \_\_\_\_\_

\_\_\_\_\_

Phone # : \_\_\_\_\_

**Privacy Policy**

By signing, you acknowledge that you have read and understand our privacy policy.

**Financial Policy and Authorizations**

If your health insurance requires pre-authorization or referral, please be sure that you have taken care of this responsibility before our office performs billable services.

**You are responsible for payment of all charges incurred at Performance Chiropractic. This responsibility extends to the total charges without regard to possible insurance benefits or determinations of necessity. Wellness treatments are not covered by or submitted to insurance.**

You authorize Performance Chiropractic to request and/or release medical records to/from your insurance company and your referring and/or family physician.

We will file your insurance claims (if applicable) for you, and you authorize the assignment of all benefits to Performance Chiropractic.

You agree to pay any and all collection costs generated in the collection of payment for all charges incurred at Performance Chiropractic. If they become necessary, these collection costs include but are not limited to special postage expense, collection agency fees, attorney fees, and court costs.

**Payment is expected at time services are rendered.**

We reserve the right to charge a \$50 missed appointment fee.

*Your initials indicate that you have read, understand, and accept all terms:*

1307 Jamestown Road, Suite 103, Williamsburg  
727 J. Clyde Morris Blvd., Newport News

Performance Chiropractic  
**New Patient Administrative**

Patient Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
*If patient is under 18 years old, parent or guardian must sign : \_\_\_\_\_*