Patient Information required

Full Name: ________________________________

I prefer to be called : ______________________

Age : ________ Birthdate : _______________

Social Security # : _______________________

Address : __________________________________

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City: _____________________________________

State: _________ Zip: ____________________

Home Phone 1: ____________________________

Work/ Daytime Phone 2: ____________________

E-mail address: ____________________________

How did you hear about us? _________________

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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 : _________________________________

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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:

Patient Signature ____________________________ Print Name ______________________ Today's Date _______

If patient is under 18 years old, parent or guardian must sign : ____________________