

HEALTH 4 LIFE  
**Patient Information Form**

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Name you prefer to be called by: \_\_\_\_\_ Gender:  M  F

Email Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Marital Status:  S  M  D Spouse's Name (if applicable) \_\_\_\_\_

Employer: \_\_\_\_\_ Wk Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Member ID: \_\_\_\_\_ Group# \_\_\_\_\_

Is your condition due to an accident?  Y  N Date of your accident: \_\_\_\_\_

Whom may we contact in case of an emergency? \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Has anyone in your household been a patient here before?  Y  N If yes, who? \_\_\_\_\_

Who is responsible for this bill? \_\_\_\_\_

*Health insurance is a very positive benefit for many families and plays a major role in helping folks obtain good chiropractic care. The primary objective of all types of health insurance is to aide you by partially paying for certain health care expenses.*

*We will be happy to call and verify your chiropractic benefits with your insurance company however, this is not a guarantee of payment, we can only inform you of what the benefits are as they were quoted to our office the day we verified them. Therefore, we strongly encourage you to take the information that we will provided to you and call your insurance company again yourself. Understand that you are responsible for all co-payments and non-covered services and that if you are in a deductible period that you are responsible for payment at the time of service unless other arrangements have been made.*

*Submitting insurance forms, billing, and rebilling can drive up the cost of chiropractic for you and our office. Therefore, we have adopted a system which greatly simplifies and reduces the cost and time involved in submitting your insurance claim. We will electronically submit your claim form for your insurance company to process your claim. However, if services are denied we ask that you take an active part and contact your insurance company and resolve it with them.*

*With this claim system, you will be able to work with your own insurance company and our staff will be better able to do what we do best.... Care for your nervous system. We appreciate your cooperation with this system in order to keep our mutual costs of paperwork, and billing down.*

*Please remember, your insurance contract is between you and your insurance company. Our involvement is to provide chiropractic care and as a convenience to you, make every effort to help you claim the maximum benefits that your insurance offers. Regardless of your insurance coverage, you have the final and full responsibility for costs incurred at our office. Please understand that balances over 60 days are subjected to accrued interest of 1.5 percent per month. Payment arrangements may be made if necessary.*

*I authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee.*

*I authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.*

*Thank you again for your cooperation.*

**HIPPA Compliance Acknowledgement of Receipt**

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notices of our privacy practice. We protect your health information and what rights you have regarding it, if we need to disclose your health information outside of our office for these reasons we will ask for your written permission. If you would like a copy of this policy please feel free to ask for one.

I acknowledge that I have reviewed this policy and that I was offered a copy of the "Notice of Privacy Practices"

Signature: \_\_\_\_\_ Date: \_\_\_\_\_