

CONFIDENTIAL PATIENT INFORMATION

Patient Information

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Phone (H) _____ Cell phone _____ SSN# _____

Age _____ Birth Date _____ Email address _____

Driver's License # _____ Marital: M S W D Children (#) _____

Occupation _____ Employer _____

Address _____ Phone _____

How did you hear about our office?

Friend Yellow Page Website Doctor Family Newspaper Insurance Website Other _____

Referred By _____ Primary Care Doctor _____

Payment Information

Insurance Medicare Cash Medicaid Other _____

*Payment is expected at Time of Service Unless Other Arrangements Have Been Made.

Insurance Information

Primary Insurance Carrier _____ Plan Name _____

Group # _____ Policy #/Insured ID# _____

Relationship to Insured _____

Insured Last Name _____ First _____ MI _____

Address _____ Phone _____

Date of Birth _____ SSN# _____ Sex M F

Employer/School _____ Work Phone _____

Accident Information

Is condition due to an accident? Yes No Date _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?

Auto Insurance Employer Worker Comp Other

Attorney Name (if applicable) _____

Policy Holder

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT ACCESS CHIROPRACTIC CENTER WILL ASSIST WITH REPORTS AND FORMS NECESSARY IN MAKING COLLECTION FROM YOUR INSURANCE COMPANY AND THAT ANY AMOUNT PAID DIRECTLY BY YOUR INSURANCE COMPANY WILL BE CREDITED TO YOUR ACCOUNT BALANCE UPON RECEIPT. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ME ARE CHARGED DIRECTLY TO ME AND THAT I AM ULTIMATELY RESPONSIBLE FOR FULL PAYMENT. I ALSO UNDERSTAND AND AGREE THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED ME WILL BE IMMEDIATELY DUE AND PAYABLE. FURTHERMORE, I AUTHORIZE, ACKNOWLEDGE LIEN, AND ASSIGN PAYMENT, OBLIGATED TO ME BY ANY INSURANCE COMPANY, TO ACCESS CHIROPRACTIC CENTER DIRECTLY FOR SERVICES RENDERED TO ME. I ALSO UNDERSTAND AND AGREE THAT I WILL NOTIFY ACCESS CHIROPRACTIC CENTER IF THERE ARE ANY CHANGES IN INSURANCE COVERAGE OR ATTORNEY REPRESENTATION.

Patient's Signature _____ Date _____

Guardian/Spouse Sig. Authorizing Care _____ Date _____

Access Chiropractic Center, L.L.C.

2253 Celanese Road
Rock Hill, SC 29732
(803) 366-7400

The undersigned acknowledges that he/she has requested healthcare services from Access Chiropractic Center. Prior to receiving any services, however, the undersigned needs to be made aware of the following:

Consent for Treatment

I acknowledge and understand that, in presenting myself for treatment and continuing chiropractic care at Access Chiropractic Center, that I authorize and consent to the administration and performance of all tests and treatments that may be ordered by the physician and carried out by the physician or members of the staff. Minors must be accompanied by a parent/legal guardian for chiropractic care except when the minor is seeking specific services for which they are not required to obtain parental consent or guidance, as clearly expressed by State Law.

Office Appointments

When you make an appointment, we are reserving time on a physician's schedule that is no longer available to other patients. If you cannot keep an appointment, we ask that you cancel your appointment at least 24 hours in advance. The office's voice mail message center (803) 366-7400 accepts messages about appointments 24-hours/day. Patients who miss appointments without providing at least 24-hours notice will be charged. Similarly, late arrivals can create scheduling problems with other patients. If you must be late, please call to let us know. By signing below you allow Access Chiropractic Center to call/leave messages to remind you about appointments and/or send you health related information by mail.

Disclosure/Authorization of Information

1. Disclosure of your protected health information without authorization is strictly limited to defined situations that include insurance company requests, emergency care, quality assurance, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request in writing, restrictions on your disclosures. You may inspect and receive copies of your records. Access Chiropractic Center will furnish your copies within 30 days after receipt of written request for records.
2. I authorize Access Chiropractic Center to release my chiropractic information or copies from my chiropractic record within reasonable time frame to the insurance companies, third party payers, or authorized agents; or claims review organizations in order to process a claim for payment on my behalf. This information may be disseminated to any and all employers insurance companies or their designees who may provide coverage for chiropractic charges and to comply with the requirements of any professional review organization. This authorization may be revoked at any time by the patient in writing.

Assignment of Benefits

In consideration of these chiropractic services, I hereby assign, transfer and set over to the Access Chiropractic Center, all my rights, title and interest to chiropractic reimbursement benefits under my insurance policy(s) as indicated below. If my insurance benefits are provided through ERISA plan I hereby assign transfer, and set over all my rights, title and interest as beneficiary of the ERISA plan to Access Chiropractic Center, with regard to my treatment and care with this practice.

Payment Agreement

I hereby assume full responsibility for and agree to pay all costs, charges, and expenses incurred by the patient, to Access Chiropractic Center. I understand and agree that this understanding constitutes a direct primary and personal undertaking by me and is not conditioned or contingent upon payment of any such costs, charges or expenses by any third party. And assignment of benefits of any insurance policy or chiropractic reimbursement plan shall not be deemed waiver of the Provider's right to require payment directly from the undersigned. The Provider expressly reserves the right to require such payment. In the event this obligation remains unpaid and requires referral for collection, the undersigned agrees to pay all costs of collection, including, but not limited to reasonable attorney's fees. If the undersigned is more than one person every obligation hereunder shall be joint and several.

All deductibles and co-pays are due at the time of services. We accept cash, check, or Visa/Master/Discover/AMEX cards. Our charges are usual and customary for our area. You are responsible for payment regardless of any insurance company's determination of usual and customary rates, unless we have a participating agreement with that company.

I have initialed, understand, and agree to the above statements.

Signature of Patient/ Parent/ Guardian

Date