

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

Patient #: \_\_\_\_\_

### ***About You***

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

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

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

Phone: (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

Email: \_\_\_\_\_

◇ Male ◇ Female ◇ Single ◇ Married ◇ Coupled ◇ Divorced ◇ Widowed

Birthdate: \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_

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

Whom may we thank for referring you/how did you hear about our office? \_\_\_\_\_

\_\_\_\_\_

### ***Your Family***

Spouse/Significant Other: \_\_\_\_\_

His/Her Occupation: \_\_\_\_\_ His/Her Employer: \_\_\_\_\_

Names/Ages of Children: \_\_\_\_\_

\_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_

Phone: (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

### ***Primary Care Physician***

Who is your primary care physician? \_\_\_\_\_

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

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

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

When doctors work together, it benefits you. May we have permission to update your medical physician regarding your care in our office? Yes \_\_\_\_\_ No \_\_\_\_\_

## ***Accident Information***

Is this condition due to an accident?     Yes     No

Type of accident     Auto     Work     Home     Other \_\_\_\_\_

To whom have you made a report of your accident?

Auto Insurance     Employer     Worker Comp     Other \_\_\_\_\_

Accident insurance company (Auto/Worker Compensation) \_\_\_\_\_

\_\_\_\_\_

Claim Number: \_\_\_\_\_

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

\_\_\_\_\_

Insurance Adjuster: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Fax Number : \_\_\_\_\_

Attorney Name (if applicable): \_\_\_\_\_



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## **Financial Policy East End Chiropractic**

Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. We ask that you read and understand our policy as it applies to your particular situation.

**Patients without insurance:** We request that 100% of the charges be paid at the time of the visit unless other arrangements have been made and agreed on prior to service. A payment plan can be established in writing.

**Group or individual insurance:** When possible, we will call to verify benefits on your insurance. However, the benefits quoted to us by your insurance company are not a guarantee of payment. Payment will be due by you at the time of service for any non-covered services, deductibles or co-pays.

**“On The Job” Injury (Workers Compensation):** If you are injured on the job, you will need to inform your employer of the accident and obtain the name and address of the carrier of their workers compensation insurance, as well as any information regarding your claim. If you do not provide us with this information, if a settlement has not been made within three months, or if you suspend or terminate care, any fees and services are due by you immediately.

**Personal Injury or Automobile Accidents:** Please notify your auto insurance carrier of your visit to our office immediately. Notify East End Chiropractic immediately if an attorney is representing you. Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six months after your care is initiated. Once the claim is settled or if you suspend or terminate care, any fees for services are due by you immediately.

**Medicare:** We do not accept assignment from Medicare. You are responsible for payment of the Medicare-priced services at time of service and Medicare will reimburse you, the patient, directly. The only chiropractic service Medicare will cover is manual manipulation of the spine. Our office completes and files the claim forms for Medicare at no charge to you.

**Secondary Insurance:** Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

**INSURANCE AUTHORIZATION**

*I understand that my insurance is an arrangement between myself and my insurance, NOT between Dr. John P. Olsen and my insurance company. I request that East End Chiropractic, PLLC prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond or if I suspend my schedule of care as prescribed by Dr. John P. Olsen, that fees will be due and payable immediately.*

*I authorize the release of any information concerning my health and health care services to my insurance companies, pre-paid health plan, or Medicare.*

*I understand that there is no guarantee that my insurance companies, pre-paid health plan, or Medicare will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges.*

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## Summary of East End Chiropractic, PLLC Privacy Policy

Your protected health information may be used and disclosed to carry out treatment, payment or health care operations. You may revoke this consent at any time by notifying East End Chiropractic, PLLC in writing, except to the extent East End Chiropractic, PLLC has taken action and reliance on your consent.

Please refer to the Notice of Privacy Practices for Protected Health Information (Privacy Notice) for a more complete description of the uses and disclosure that East End Chiropractic, PLLC may use your protected health information. You have the right to review the Privacy Notice prior to signing the consent.

In accordance with the law, the terms of the Privacy Notice may change. At any time, you may obtain a copy of the current Privacy Notice and any revised notice by requesting the Privacy Notice in writing or by requesting a notice in person.

You have the right to request East End Chiropractic, PLLC to restrict the manner in which your protected health information is used or disclosed to carry out treatment, payment, or health operations. East End Chiropractic, PLLC is not required to agree to the requested restrictions. If East End Chiropractic, PLLC agrees to the requested restriction, East End Chiropractic will honor the request and it will be binding on the office.

*I hereby consent to the use and disclosure by East End Chiropractic, PLLC, its workforce and its business associates of my protected health information for the purposes of treatment, payment and health care operations.*

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Guardian: \_\_\_\_\_ Date: \_\_\_\_\_