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Name: _____ Today's Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
€ Male € Female Date of Birth ___/___/___ Age ___ Height ___ Weight ___ SS# _____
Marital Status: € Single € Married € Divorced € Widowed € Separated
Email Address: _____ How did you hear about us? _____
Your Employer: _____ Occupation: _____
Name of Spouse or Parent: _____ Date of Birth ___/___/___
Spouse / Parent employed by: _____ Occupation: _____
Work Phone: _____ Spouse / Parent SS#: _____

Are we seeing you for an injury from:

€ Auto € Sports Injury € Work
€ Other € No injury

EMERGENCY CONTACT INFORMATION:

Emergency Contact Person: _____
Phone #: _____ Relationship: _____

INSURANCE INFORMATION: € I will be paying for the services myself € Medicare _____
PLEASE BILL: € Auto Insurance € Health Insurance Other _____

OFFICE FINANCIAL POLICY:

1. All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff.
2. This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed in your report of findings.
3. If you have insurance, we will gladly accept assignment with the exceptions and regulations, as stated below in 4 and 5, (provided we have prior certification from you insurance company).
4. We accept assignment for the initial treatment plan only. Any follow-up visits will be payable when services are rendered. Once you have been discharged from active care and placed on maintenance care, we will continue to file your insurance but require full payment per visit.
5. We accept assignment as a courtesy to you; you are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with same, as your contract is between you and your insurance company.
6. If you receive any worksheets from your insurance company or explanation of benefits, please bring this information into the office as soon as possible. We must have a copy of this to determine if proper payment has been made. If you should receive a check from your insurance company during our billing, you must bring it into the office upon receipt. If any overpayment exists after all insurance billing has been done, we will issue you an overpayment check – it will not come from your insurance company. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due.
7. I hereby assign my major medical insurance benefits, including Medicare, private insurance and other health plans to Prolific Chiropractic, PC.
8. I understand I am financially responsible, WHETHER OR NOT MY INSURANCE COMPANY PAYS, for all charges incurred by me. Any services not covered or coverage reductions by your insurance will be your responsibility.
9. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjustor, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.
10. If you are referred to another specialist or you discontinue care for any reason other than by discharge by the Doctor, the bill is due and payment in full shall be paid immediately; regardless of any claims submitted.
11. Prolific Chiropractic P.C. needs a minimum of 24 hours notice of a canceled, changed or missed appointment otherwise charges may be applied at \$50 per appointment. This allows other patients to schedule in that time frame.
12. If you have questions concerning this or any other matter, please speak with the Office Manager prior to seeing the Doctor.

I have read and understand the above Office and Financial Policy and agree to abide by these terms.

Patient's Signature: _____

Date: _____