

PATIENT INFORMATION

NAME _____ MI _____

HOME ADDRESS _____

CITY/STATE/ZIP _____

EMAIL _____

CELL PHONE (____) _____ - _____

WORK PHONE (____) _____ - _____

HOME PHONE (____) _____ - _____

SOCIAL SECURITY # _____

BIRTHDATE ____/____/____

EMPLOYER _____

EMERGENCY CONTACT _____

RELATIONSHIP _____

PHONE # (____) _____ - _____

STUDENT STATUS Full-time Part-time N/A

INSURANCE (only if you are not the policyholder)

POLICY HOLDER _____

SSN _____ DOB ____/____/____

POLICY HOLDER EMPLOYER _____

SUPPLEMENTAL INSURANCE IF APPLICABLE

POLICY HOLDER _____

SSN _____ DOB ____/____/____

POLICY HOLDER EMPLOYER _____

PERSON RESPONSIBLE FOR ACCOUNT

SELF _____ OTHER _____ PLEASE INDICATE

NAME _____

ADDRESS _____

CITY/STATE/ZIP _____

PHONE NUMBER (____) _____ - _____

WERE YOU REFERRED TO OUR OFFICE?

YES. IF SO, BY WHOM? _____

NO. IF NOT, HOW DID YOU FIND OUT ABOUT OUR OFFICE? _____

FINANCIAL POLICY

You will be placed into one of the following categories based on your insurance or type of injury.

1. **HEALTH INSURANCE:** Private health insurance will generally require you to pay “out of pocket” expenses in the form of a Co-pay, and/or a Deductible/Coinsurance. No payment is expected from you until we call and verify your insurance. We typically do this by your **second** office visit, so no payment is typically due the first day. Once your insurance has been verified we require payment at or before the time of service unless other arrangements have been made.
2. **SELF PAY:** If you do not have insurance we offer a cash discount to make your care affordable. This payment is due at the time of your treatment and may **never** be billed to an insurance company.
3. **MOTOR VEHICLE ACCIDENTS:** If your condition is the result of an automobile accident we require that you open a “Med-pay” account with **your own** auto insurance company. This allows timely payments for your treatment and your insurance company will be reimbursed by the responsible party after the settlement. Med-pay claims do not affect your premiums.
4. **WORK COMP:** If your condition is the result of a work injury we require that you open a work comp claim and provide us with a claim number and billing address.

***Any unpaid balances will be billed to you at the end of each month and a \$10.00 billing charge will be assessed. We reserve the right to send any account over 90 days old to a collection agency and charge interest at 16% APR.

I have read and understand the financial policy. NAME _____ DATE _____