BYERS CHIROPRACTIC CENTER

PATIENT INFORMATION SHEET

Name (please print): _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (H): _____(cell): _____

Date of Birth: _____ SS#: _____

Gender: ___M ___F Marital Status: M S W D

E-mail address: _____

INSURANCE INFORMATION

Primary Ins.: _____ Effective Date: _____ Co-pay: _____

Policy Holder: _____ Phone Number: _____

Relationship to Patient: _____ Date of Birth: _____ SSN: _____

ID. Number: _____ Group Number: _____

Employer: _____
(name) (address) (phone)

We do not bill Secondary Insurance unless you have State or Government funded healthcare:

Secondary Ins.: _____ Effective Date: _____ Copay: _____
Policy Holder: _____ Phone Number: _____

Relationship to Patient: _____ D. O.B.: _____ SSN: _____

ID. Number: _____ Group Number: _____

Employer: _____
(name) (address) (phone)

EMERGENCY CONTACT INFORMATION

Name: _____ Ph: #_____ Relation: _____

Name: _____ Ph: #_____ Relation: _____

PATIENT EMPLOYMENT INFORMATION (if different that policy holder info.)

Employer: _____ Occupation: _____

Address: _____

Phone #: _____

BYERS CHIROPRACTIC CENTER

PATIENT INFORMATION SHEET

MISCELLANEOUS INFORMATION

Family Medical Doctor: _____ Phone #: _____

Who may we thank for referring you to our office: _____

Consent to Treat and Authorization to Release Information and Financial Responsibility

I request the insurance carrier to pay directly to Byers Chiropractic Center the amount due for any services rendered. I also agree to pay any amount that the insurance company deems as not a covered benefit and also any amount the insurance company determines to be my responsibility. I agree to treatment deemed necessary by the physician and authorize the release of any medical information required by the involved parties to be necessary to process this claim.

I also agree that if for any reason I receive payments sent directly to me from insurance companies, I will bring payment and associated paperwork to Byers Chiropractic Center. These payments are expected as part of the total cost of my treatment and failure to submit them to Byers Chiropractic Center will result in receiving a bill for unpaid services. Any outstanding unpaid bill 60 days overdue will incur 3% APR interest on the total balance. Unpaid bills with outstanding balances over 120 days will be sent to an outside collection agency with an additional 40% fee of the balance due tacked onto the account.

_____ _____
Signature of patient/patient representative Date

_____ _____
Relationship to patient Date

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledgement that I have received a copy of Byers Chiropractic Center Institute's Notice of Privacy Practices with an effective date of September 23,2013.

_____ _____
Signature of patient/patient representative Date

_____ _____
Relationship to patient Date