Creekside Chiropractic Center

PATIENT INFORMATION

Last Name:		**First:**			**Middle:**
Marital Status (Please circle one):	**Single**	**Married**	**Divorced**	**Widowed**	**Birth Date:**	**Sex: M F**
Social Security No:		**Home Phone:**			**Cell Phone:**
Street Address:					
City:			**State:**		**Zip Code:**
Patient's Email Address: (email address is for office use only)					

Family Physician: _____

Location: _____ _____

Permission to contact Y or N

ACCIDENT INFORMATION

Is this condition due to an accident Y N Date: _____

Type of Accident ☐ Auto ☐ Home ☐ Work ☐ Other

To whom have you made the report of incident?_____

Occupation:		**Employer:**		**Employer Phone:**
(Please circle work status):	**Full-Time**	**Part- Time**	**Full-Time Student**	**Part-Time Student**	**Not Employed**

Whom may we thank for referring you to us? _____ **Family/Friend** ☐ **Attorney** ☐ **Doctor** ☐

Insurance Provider Book/Web ☐ **Activator Website** ☐ **Small Yellow Pages (Gahanna)** ☐ **Other** ☐

INSURANCE INFORMATION

Name of Insured:	**Birth Date of Insured:**	**Is this person a patient here? Yes No**
Name of Insurance:	**Subscriber's Social Security No:**	**Subscribers Birth Date :**
Patient's relationship to subscriber:	**Self Spouse Child Other**	

Our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPPA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information release to family embers you must sign below. Signing this form will only give information to family members indicated below. I authorize Creekside Chiropractic Center, LLC to release my medical and/or billing information to the following individuals.

1. _____ **Relation to Patient:** _____
2. _____ **Relation to Patient:** _____
3. _____ **Relation to Patient:** _____

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	**Relationship to patient:**	**Home Phone:**	**Work Phone:**

Authorization and Release: I authorize payment of insurance benefits directly to Jodi L. Cooley, DC, Michael A. Fisher, DC or to Creekside Chiropractic Center LLC. I authorize the doctor to release all information necessary to communicate with personal physicians and other health care providers and payors to secure the payment of benefits. I understand that I am responsible for all cost of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, and fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16%.

I understand and agree to allow Creekside Chiropractic Center LLC to use my protected patient health information for the purpose of treatment, payment, health care operations, and coordination of care. If you would like to review the complete notice of privacy practices before signing this form, it is avabilbe upon request at the front desk. If there is anyone you do not want to receive your medical records, please inform our office.

Patients or Authorized Person's Signature: The above information is true to the best of my knowledge. I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization card. I authorize payment of medical benefits to Creekside Chiropractic Center LLC for services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing. I agree to pay for services not covered by insurance and understand that I am ultimately responsible for payment in full at this office.

Patient/Gardian Signature_____**Date**_____08/11/17 ked