NEW PATIENT INFORMATION

This form MUST be completed in its entirety

Today's Date:_____

Name:_____ Date of Birth:_____

Address:_____ City:_____Zip:_____

Home #:_____ Work #:_____ Mobile #:_____

E- mail Address:_____

Occupation: _____ Employer: _____

Insurance Company:_____

Insurance ID or Policy#:_____ Group#:_____

Referring Physician: _____ Primary Physician _____

If this is your spouse / parent's insurance we need the following:

_____ _____ _____

Parent / Spouse Name | Date of Birth | Phone #

Is this work related / worker's comp? ( ) yes ( ) no Date of injury: _____

How did you hear about us?

( ) Doctor's office ( ) Our Website ( ) Social Media ( ) Insurance Company

( ) Referral: (if so whom can we thank) _____

Emergency Contact: _____ _____ _____

Name | Relation | Phone #

DISCLAIMER

Please be advised that during your treatment sessions, all discussions may be transcribed for the sole purpose of medical documentation. This transcription will be used to accurately record details of your care for clinical and administrative purposes, and will remain confidential in accordance with privacy regulations (e.g., HIPAA in the United States). By proceeding with the session, you acknowledge and consent to the recording of your information for these purposes. If you have any questions or concerns, please inform the provider prior to the start of the session.

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*We will be happy to bill your insurance **as a courtesy**. If payment is not received within 60 days you will receive a bill from our office. You will have 30 days to follow up with your insurance company. After 90 days you will be responsible for paying any unpaid balance*. Please be aware that we reserve the right to charge up to a **$50.00** charge for any "no-show" appointments or appointments canceled without 24 hour notice. By signing below you confirm that you have read, understand and agree with these terms .

_____ _____

Signature (parent if patient is a minor) | Date

To bill your insurance we MUST obtain a copy of both the front & back of your insurance card