CAROLINASCHIROPRACTIC
AND SPINAL REHAB

Patient Intake Form

Patient Information

Full Name: _____ Date: _____
First MI Last

Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Birth Date: _____ Gender: _____ Marital Status: _____

Social Security Number: _____ Email Address: _____

Home Phone: _____ Work Phone: _____ Cell/Other: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Email Confirmation ☐ Text Message to my Cell Phone: **Please list your cell phone carrier:** _____

Employer: _____ Occupation: _____

How did you hear about our office? _____

Emergency Contact Information

Spouse's Name: _____ Spouse's Date of Birth: _____

Emergency Contact: _____ Emergency Contact Phone Number: _____

Payment Information

Please have your insurance card and photo ID ready so they can be copied for the clinic's records.

Person Responsible for Payment: _____ Phone: _____

Do you have health insurance? ____ Yes ____ No Who is the Policy Holder? _____

Policy Holder's date of birth: _____ Do you have HSA? _____ or HRA? _____

Financial Responsibility: I understand that insurance billing is a courtesy provided to me by Carolinas Chiropractic and Spinal Rehab and I am at all times financially responsible for any charges not covered by health care benefits. I understand copays, co-insurance, and deductibles are due at the time of my visit as well as any prior balance I may owe. I understand that I assign benefit to be paid by my insurance company directly to the provider of services rendered to me. I understand my balance will automatically be referred to an outside collection agency should my account surpass 90 days without payment activity. I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

Office Policies

Re-Exam Policy - If a patient has not been seen in our office for 90 days, they present with a new injury or area of complaint, or if insurance has changed they will be subject to a re-examination and a subsequent re-exam charge.

Cell Phone Policy - In an effort to keep a relaxing environment, please silence your cell phones and all electronic devices while in the office and please step outside to make or receive phone calls.

Cancellation Policy - We understand that there are emergencies and we will be sensitive to those issues; however we respect your time and ask that our time be respected as well. Please be advised that there is a $40 fee for all missed appointments without suffiecient notice. Please notify us by 2:00pm on the business day prior to your scheduled appointment to avoid a fee.

Children in the Office Policy - While we welcome children in our office, we do ask that you have an adult available to accompany them should they need to step out of the exam room or wait in the waiting room.

Late Appointment Policy - If you arrive more than 15 minutes late for your appointment, we may ask that you reschedule.

I, the undersigned, understand and agree to the above and, in order to be accepted as a new patient in this office, agree to abide by these policies.

Signature _____ Date _____

Authorization for Release of Information

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA 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 released to family members, you must sign this form. Signing this form will only allow us to give information to family members indicated below.

I authorize Carolinas Chiropractic and Spinal Rehab to release my medical and/or billing information to the following individuals(s):

1._____ Relation to Patient:_____

2._____ Relation to Patient:_____

3._____ Relation to Patient:_____

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient.

Consent for Treatment

Assignment & Release - By signing below, I authorize Carolinas Chiropractic and Spinal Rehab, LLC to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Carolinas Chiropractic and Spinal Rehab, LLC and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.

By signing below, I give my consent for examination and the performance any tests or procedures needed. I, the undersigned, understand and agree to the above and, in order to be accepted as a patient in this office, agree to abide by these policies.

If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient.

Signature _____ Date _____