BEACHY FAMILY CHIROPRACTIC – MATTHEW J. BEACHY, D.C.

751 MILL ROAD – BELLVILLE, OH 44813 - (419) 886-7007 (p) ~ (419) 886-2080 (f)

Confidential Patient Information **Date:________________**

Patients Name: _______________________________ Chief Complaint: _____________________________

Address: ____________________________________ Home Phone: _________________________________

City: ________________________ Zip:__________ Cell Phone: ___________________________________

SS#: _______________________________________ Email: _______________________________________

Date of Birth: ________________________________ Marital Status: M S W D

Occupation: _________________________________ Employer: ___________________________________

Address of Insured (if different than above): ____

Are your present systems or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) ___ Yes ___No

Family Physician: ____ (Note: May we send your health information to this provider **Y / N**)

Person to contact in case of emergency (Name and Phone): ____

Have you ever been under Chiropractic Care? Y N If so, Who? ____

Have you had any SPINAL X-Rays / MRI's / CT's taken in the last year? Y N If so, Where? ___________________________________

What operations have you had? ____ When? ________________

Serious Illness: ____ When? ________________

Infectious Diseases: ____ When? ________________

Do you have a pace maker? **Y / N** Have you ever had any Hip or Knee Replacements **Y / N**

What medications or drugs are you taking? (check those that apply): Pain Killers ____ Insulin _____ Cholesterol Meds ________

Blood Pressure Meds ___ Muscle Relaxers ___ Birth Control ___ Other: ___________________________________

What is your goal in our office? ____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to **BEACHY FAMILY CHIROPRACTIC** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I have read and fully understand this agreement.

____ ______________________________

Signature of Insured / Guardian Date

Confidential Patient Information continued….

Patient Name:___________________________________ Date:_________________

INSURANCE INFORMATION

Primary Insurance:

Ins. Company: _____________________________ Ins. Phone #: _______________________

ID#: ____________________________________ Group #: ________________________

Name of Policy Holder: _____________________ Policy Holder DOB: ________________

Policy Holders Employer:____

Secondary Insurance:

Secondary Ins. Company:______________________ Ins. Phone #:___________________

ID#:____________________________________ Group #:_______________________

Name of Policy Holder:_______________________ Policy Holder DOB:______________

Policy Holders Employer:____

Verification of benefits is the patient's responsibility. As a courtesy, we will call on your Insurance benefits, but it is your responsibility to know your benefits. We are not responsible for any discrepancies between what the Insurance says they will cover and actually DO cover. We cannot be liable for any non-covered or non-allowed services.

I understand that any amounts not paid in full could be subject to a collection fee, and sent to our collection representative, and could be placed on my credit file for non-payment of services rendered.

Patient Signature:__________________________________ Date:___________________