NEW PATIENT INFORMATION

Name: ______________________________ (Age) ______ Gender: M F

Home Address: ______________________________ Home Phone ( ) ______________

City, State, Zip: ______________________________ Work Phone ( ) ______________

Email Address: ______________________________ Cell Phone ( ) ______________

Birth Date _____/_____/_____ Social Security # ______-_____-______ Marital Status: S M D W

Occupation: ______________________ Employer Name: ______________________

Spouse's Name: ______________________ Work Phone: ( ) ____________ Cell Phone: ( ) ____________

Spouse's Employer: ______________________ Occupation: ______________________

How were you referred to this office? ______________________________

PURPOSE OF THIS VISIT

Reason for this visit – Main Complaint: ______________________________

Is this purpose related to an auto accident / work injury? Yes ☐ No ☐ If so, when: ______________

When did this condition begin: ______/____/______ Did it begin: Gradual Sudden Progressive over time

What activities aggravate your symptoms? ______________________________

Is there anything which has relieved your symptoms? Yes ☐ No ☐ Describe: ______________

Type of Pain: Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting

Does the Pain radiate into your: ___Arm ___Leg ___Does not radiate

How often do you experience these symptoms throughout the day? 100% 75% 50% 25% 10% Only with Activity

Does complaint(s) interfere with: ___Work ___ Sleep ___ Hobbies ___Daily Routine Explain: ______________

Have you ever experienced this condition before? Yes ☐ No ☐ If so, please explain: ______________

Who have you seen for this? ______________________ What did they do? ______________________

How did you respond? ______________________________

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? Yes ☐ No ☐ Who? ______________ When? ______________

Reason for visits: ______________________________

How did you respond: ______________________________

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability: Initials: ______

The statements made on this form are accurate to the best of my knowledge and I agree to allow this office to examine me for further evaluation.

Patient Signature: ______________________________ Date: ______________

Guardian Signature: ______________________________ Date: ______________

Marsh Chiropractic & Wellness Center

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR FROM PRIVATE AND GROUP HEALTH INSURANCE, ACCIDENT, AND AUTOMOBILE INSURANCE

I hereby authorize and instruct any insurance company from which payment may be forthcoming to cover any services rendered at this office, (including but not limited to chiropractic adjustments, therapy, exams, x-rays, supplements) to make direct payment to Marsh Chiropractic for any medical benefits for any and all treatment in a timely manner. If my current policy prohibits direct payment to doctor, then I hereby instruct and direct you to make the check payable to myself and Marsh Chiropractic. I authorize the release of any medical or other information necessary to process any claim for reimbursement of charges incurred to any insurance company, adjuster, or attorney involved in this case. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service chargers over and above this insurance payment. I further agree that this authorization and release is irrevocable and ongoing until all monies owed are paid in full. This authorization and release will be in continual effect until revoked by both parties. I have read the above information and I understand my insurance benefits. I also understand that this is not a guarantee of payment of claims. I understand all services rendered to me are ultimately my financial responsibility, and I am obligated to pay for all usual and customary benefits denied by my insurance carrier. A photocopy of this assignment shall be considered as effective and valid as this original.

Under my health plan, I am financially responsible for co-payments, co-insurance and/or deductibles for covered services. I am also financially responsible for all non-covered services, including care determined by my insurance company or plan to be elective, wellness, chronic, or maintenance. Elective, wellness, chronic, or maintenance care are treatments that do not significantly improve a clinical condition. While being treated for a chronic condition, I may elect to receive care beyond that which is determined to be medically necessary. I may elect to receive care beyond that which is determined to be medically necessary. I may also choose to receive wellness or maintenance care once maximum therapeutic benefits from treatments have been reached. If, during the course of these types of care, I develop a new condition or a previous condition becomes significantly worse, care may no longer be considered maintenance/elective and may then be covered by my health plan. I agree to be personally responsible for any and all fees involved in the collection of any overdue account. I also understand there is a $25 billing fee for each and every billing attempt made by Marsh Chiropractic.

If you are unable to keep a scheduled appointment, please give notice at your earliest convenience. If notice is not given before your appointment time, we reserve the right to charge the typical office fee for your appointment.

I acknowledge that I have been told in advance by my provider or his/her staff that the services listed above may not be covered by my health plan. If these types of care fall under my plan's definition of non-covered care for any reason, I agree to pay for these services. This agreement is irrevocable by anyone other than Marsh Chiropractic until all outstanding balances are paid in full.

Signature: ______________________________ Date: ______________