

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:	Reason for Visit?			Is injury auto accident related? Y N	
				Is injury work related? Y N	

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 <input type="checkbox"/>	Attorney <input type="checkbox"/>	Doctor <input type="checkbox"/>
Insurance Provider Book/Web <input type="checkbox"/>	Big Yellow Pages (Columbus) <input type="checkbox"/>	Small Yellow Pages (Gahanna) <input type="checkbox"/>		Other <input type="checkbox"/>	

INSURANCE INFORMATION			
Name of Insured:	Birth Date of Insured:	Address(If Different):	Home Phone:
Is this person a patient here? Yes No			
Name of Insurance:	Subscriber's Social Security No:	GroupNo:	Policy/ID No:
Patient's relationship to subscriber:	Self Spouse Child Other		
Name of Secondary Insurance:	Subscriber's Name:	Group No:	Policy/ID No:
Patient's relationship to subscriber:	Self Spouse Child Other		

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 or to Creekside Chiropractic Center. 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 to use my protected patient health information for the purpose of treatment, payment, health care operations, and coordination of care. If you would like a more detailed account of our privacy policies and procedures we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this form. 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 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 _____

Creekside Chiropractic Center

Financial Policy

Insurance

If you have insurance, we will do our best to help you receive maximum benefits. Insurance is a contract between you and your insurance company. We are not a party to this contract. When possible, we will call your insurance company to verify your benefits. However, the benefits quoted to us by your insurance company are not a guarantee of payment. Through a third-party billing company, we will file insurance claims to your insurance carrier(s) if you have supplied us with all the necessary information. Our office will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than supply factual information as necessary. You are responsible for the items listed above as well as any services considered "not medically necessary" by your insurance company. We participate with most insurance companies; however, if we do not participate with your insurance company, you are responsible for all out of network deductibles and co pays.

Referrals / Pre-authorizations

If your insurance requires a referral and/or pre-authorization for services, you are responsible for obtaining it. Failure to obtain a referral or pre-authorization may result in lower or no payments from the insurance company. You would be responsible for any unpaid balances. You are ultimately responsible for knowing your insurance benefits.

Medicare

We do accept assignment from Medicare. Medicare pays 80% of the allowable fee after your deductible has been met. **Medicare will cover the chiropractic adjustment only and for active conditions only.** Medicare does not cover chiropractic adjustments for maintenance or additional modalities or therapies. Medicare supplemental policies will cover only those charges that Medicare also allows. You are responsible for your Medicare deductible and all coinsurance.

Cash Services

We request that 100% of payment is made at the time of service unless prior arrangements have been made. If your situation requires that you are a self pay patient (e.g. you have no insurance, your chiropractic health insurance benefits have been exhausted or your co pay or out of network deductible is extremely high), please inquire with the front desk about our cash services policy.

Workers Compensation

If you are injured on the job, your care may be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of their insurance carrier. If your claim is not allowed, you will be responsible for all charges accrued during your care. Additionally, please let us know if you are currently working with an attorney.

Personal Injury

Please notify your auto insurance of your visit to our office immediately. Although you are ultimately responsible for any charges accrued during your care, we will wait for a settlement of your claim for up to 6 months after your care is completed. Once the claim is settled or if you suspend or terminate care all fees for services are due immediately. Additionally, please let us know if you are currently working with an attorney.

Financial Hardship

It is unlawful to routinely waive/fail to collect or discount co-payments, deductibles, coinsurance or other patient responsibility payments per the federal false claims act, federal anti-kickback statute, state and federal insurance fraud laws. It is also a violation of our managed care contracts. If you have a true financial hardship, please notify the front desk staff. You will need to provide appropriate documentation that shows you are unable to pay medical bills. All information relating to financial hardship requests will be kept confidential.

Patient/Guardian Signature

Date