PATIENT PERSONAL INFORMATION

Name: _____ Sex: ❑Male ❑Female Today's Date: _____

Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed Birth Date: ____/ ____/ ____

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

SS#: _____-_____-_____ Occupation: _____ Employer: _____

Business Address: _____ Work Phone: _____

Email Address: _____ Home#: _____ Cell#: _____

Do You have any children? ___Yes ___No Number of children_____

Name of Spouse/Parent/Guardian: _____ Birth Date: ____/ ____/ ____ Age: _____

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

Occupation: _____ Employer: _____

Business Address: _____ Work Phone: _____

Email Address: _____ Home#: _____ Cell#: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Did you visit our website? **YES** **NO** Who may we thank for referring you? _____

Do you have insurance? **YES** **NO** Insurance Company Name: _____

OFFICE POLICIES REQUIRING PATIENT SIGNATURE

1) PRIVACY NOTICE TO PATIENTS: I acknowledge that I have been shown and asked to read the Nob Hill Chiropractic Privacy Notice to Patients. I further understand that this information shall be posted and accessible to me at any time I visit the office. If I have any questions I can ask the staff and if I have any complaints I can contact the office at 265-9656. _____
2) RELEASE: Please read HIPAA Notice of Privacy Practices. Initial if you agree to the information provided. _____
3) ASSIGNMENT OF BENEFITS: I hereby assign payment directly to this office for professional services rendered. I am personally responsible for payment regardless of insurance coverage. _____
4) Health and accident insurance policies are an arrangement between an insurance carrier and me. If the carrier has not paid a claim within 60 days, I am responsible for recovery of the claim _____
5) Medicare Patients: I am aware that services received at Nob Hill Chiropractic will not be allowed by Medicare and no reimbursement will be paid by Medicare for these services as detailed in the Medicare contract I have signed with Nob Hill Chiropractic. (ABN Form) _____
6) This office will prepare any necessary reports and forms to assist me in making collections from my primary insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. _____
7) Any balances outstanding for longer than 30 days will be charged a 2% interest rate per month and I agree to pay any said charges. In the event that my balance is referred to an agency or attorney for collection purposes, I agree to pay reasonable fees and any expenses or costs relating to the collection proceedings, including court costs. _____
8) CANCELLATION POLICY: Cancellations require 24 hours notice. Missed appointments will be charged in full. Appointments changed with less than 24-hour notice will be billed $25.00. _____

Patient Signature: _____ Date: _____ Witness: _____

CONSENT TO TREATMENT OF A MINOR/CHILD

I hereby authorize Dr. Stephen Gardner and whomever he may designate to administer chiropractic care as he/she seems necessary to my son/daughter. Name of Child: _____

Patient Signature: _____ Date: _____ Witness: _____