Mills River Family Chiropractic, P. A.

Drs. Tom and Laura Gross
Chiropractic Physicians

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PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION:

TODAY'S DATE ________/_________/________

FIRST NAME ______________________________ MI ________ LAST NAME ______________________________

RESIDENCE/STREET ADDRESS ____

CITY ____________________________ STATE __________ ZIP ____________________

MAILING ADDRESS (if different from above) ____

CITY ____________________________ STATE __________ ZIP ____________________

DATE OF BIRTH ______/______/_______ SOCIAL SECURITY NUMBER ___________ - _________ - ___________

PHONE NUMBERS (Home) (_____)______-_________ (Work) (_____)_______-_________ (Cell) (_____)______-__________

OCCUPATION_________________________________ EMAIL ADDRESS ____________________________

MARITAL / RELATIONSHIP STATUS (Please circle one)

SINGLE / MARRIED / COMMITTED RELATIONSHIP / SEPARATED / DIVORCED / WIDOWED

NUMBER OF CHILDREN ________________

EMERGENCY CONTACT ______________________________ PHONE NUMBER (_______) ________ - ____________

INSURANCE / PAYMENT INFORMATION:

CASH ______ RESPONSIBLE PARTY _________________________ RELATIONSHIP TO PATIENT ______________

PRIMARY INS CO ______________________________ SECONDARY INS CO ______________________________

FIRST NAME OF INS. MEMBER ______________________ MI ______ LAST NAME_________________________

ID # ___________________ GROUP ID # _________________ PHONE NUMBER (_______) ________ - __________

MEMBER'S DATE OF BIRTH _____/_____/_____ MEMBER'S SOCIAL SECURITY NUMBER ________ - _____ - ________

DRIVER'S LICENSE # ____________________________ EMPLOYER ____________________________________

MEMBER'S RESIDENCE/STREET/MAILING ADDRESS ____

CITY ______________________________ STATE _________ ZIP ____________________

PHONE NUMBERS (Home) (_____)______-_________ (Work) (______)_______-_________ (Cell) (_____)______-_________

REFERRAL INFORMATION / HOW DID YOU FIND US? (Please circle one)

BELL YELLOW PAGES / BLUE RIDGE YELLOW PAGES / ROAD SIGN / CHIROPRACTOR
DR / HEALTH TALK / NEWSPAPER AD / GOOD LIFE / FAMILY / FRIEND / CHURCH / OTHER

PLEASE SIGN BACK OF PAGE

CONSENT FOR TREATMENT

CONFIDENTIAL

IT IS UNDERSTOOD THAT TREATMENT FOR ISSUES, THAT I PRESENT WITH, WILL BE GOAL DIRECTED TO ACHIEVE OPTIMUM HEALTH AND WELLNESS BY THE USE OF CHIROPRACTIC.

I HEREBY AUTHORIZE THE DOCTOR TO EXAMINE, ASSESS AND TREAT MY CONDITION AS HE/SHE DEEMS APPROPRIATE. I GIVE MY AUTHORITY FOR ADJUSTMENTS, MODALITIES, PHYSICAL THERAPIES OR OTHER PROCEDURES TO BE PERFORMED. THE DOCTOR WILL NOT BE HELD RESPONSIBLE FOR ANY PRE-EXISTING MEDICALLY DIAGNOSED CONDITION NOR FOR ANY MEDICAL DIAGNOSIS.

PAYMENT ARRANGEMENT

SERVICES RENDERED ARE ULTIMATELY THE RESPONSIBILITY OF THE PATIENT.

PAYMENT IS EXPECTED AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, DEBIT CARDS, MASTER CARD, VISA AND AMERICAN EXPRESS.

IF LACK OF FINANCIAL RESOURCES IS PREVENTING YOU FROM RECEIVING NEEDED CARE, PLEASE TALK TO ONE OF THE DOCTORS REGARDING A TIME/PAYMENT PLAN.

PAYMENT FOR ALL LABORATORY, NUTRITIONAL SUPPLEMENTS, DURABLE MEDICAL EQUIPMENT, ORTHOTICS, OR OTHER INVENTORY STOCK IS EXPECTED AT THE TIME OF PURCHASE.

WE PROVIDE AN INSURANCE BILLING SERVICE AS A ***COURTESY*** TO OUR CLIENTS. WE WILL VERIFY ELIGIBILITY OF BENEFITS AND BILL YOUR PRIMARY CARRIER FOR SERVICES RENDERED. WE WILL FILE PRIVATE/GROUP INSURANCES, MEDICARE, MEDICAID, WORKMAN'S COMPENSATION AND AUTO/ACCIDENT CLAIMS. WE ALSO PROCESS ATTORNEY CLAIMS. THIS SERVICE IN NO WAY GUARANTEES PAYMENT FROM YOUR INSURANCE CARRIER. **IF WE DO NOT RECEIVE PAYMENT, 60 DAYS AFTER FILING YOUR INSURANCE, YOU WILL BE RESPONSIBLE FOR PAYMENT AND FOR FOLLOWING UP WITH THE INSURANCE COMPANY**

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN THE INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT THE DOCTOR'S OFFICE WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN OBTAINING PAYMENT FROM THE INSURANCE COMPANY. ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO THE DOCTOR'S OFFICE WILL BE CREDITED TO MY ACCOUNT. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ARE CHARGED DIRECTLY TO ME AND I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I ALSO UNDERSTAND THAT IF I TERMINATE MY CARE OR TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES AND OR INVENTORY PURCHASED BY ME WILL BE IMMEDIATELY DUE AND PAYABLE.

MISCELLANEOUS FEES

NO CALL / NO SHOW APPOINTMENTS WILL BE SUBJECT TO A $20.00 FEE THAT WILL NOT BE CHARGED TO YOUR INSURANCE (Other patients need an opportunity to receive help!)

ALL RETURNS OF SUPPLEMENTS ARE SUBJECT TO A 15% RESTOCKING FEE

ALL RETURNED CHECKS ARE SUBJECT TO A $30.00 PROCESSING FEE!!

I UNDERSTAND AND AGREE TO THE ABOVE INFORMATION. I AUTHORIZE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIMS. I ASSIGN AND REQUEST PAYMENT DIRECTLY TO MY PHYSICIAN.

SIGNATURE ______________________________ **DATE** ____/____/____

WITNESS ______________________________ **DATE** ____/____/____

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