Mills River Family Chiropractic

Dr. Tom Gross, Chiropractic Neurologist
Dr. Laura Gross, Chiropractic Physician
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PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION:

Patient Information

Date____/____/____
First Name _____Mi ____Last Name _____
Billing Address_____
City _____ State _____ Zip Code _____
Phone Number (Home)( )____-_____ (Work) ( )_____-_____ (Cell) ( )_____-_____
Email Address_____ Occupation_____
Social Security Number _____-____-_____ Date of Birth _____/_____/_____

Referral Information

How did you find us?? (Please circle one)

Chiropractor Good Life, Health Talk
Newspaper Ad. Road Sign Church
Family Friend Dr
Bell Yellow Pages Blue Ridge Yellow Pages
Other_____
Name:_____

Marital Information

(Please circle one)

Single Committed Relationship Married
Separated Divorced Widowed

Emergency Contact:_____
Phone Number_____
Relationship_____

Insurance & Payment Information

Cash__ Insurance___

Responsible Party_____ Relationship To Patient _____
Primary Ins Co:_____ Secondary Inc. Co_____
Members First Name :_____MI_____ Last Name_____
ID#_____ Group ID#_____
Ins Phone Number:_____ Members Date of Birth_____/_____/_____
Members SS#_____-_____-_____ Drivers License #_____State_____
Employer:_____
Members Mailing Address:_____
City:_____State:_____Zip C ode_____

Phone Number (Home) ( )_____-_____Work) ( )_____-_____(Cell) ( )____-_____

CONCENT FOR TREATMENT

CONFIDNETIAL

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 PREFORMED. THE DOCTOR WILL NOT BE HELD RESPONSIBLE FOR ANY PRE-EXISTING MEDICALLY DIAGNOSED CONDITIONS NOR FOR ANY MEDICAL DIAGNOSIS.

PAYMENT ARRANGEMENT

SERVICES RENDERED ARE ULTIMATELY THE RESPONSIBILITY OF THE PATIENT.

PAYMENT IS EXPECTED AT 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 CARE, PLEASE TALK TO ONE OF THE DOCTORS REGARDING A TIME/PAYMENT PLAN.

PAYMENT FOR ALL LABORATORY, NUTRITIONAL SUPPLEMNTS , DURABLE MEDICAL EQUIPMENT, ORTHOTICS, OR OTHER INVENTORY STOCK IS EXPECTED AT 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, MEDICADE, 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 PURCHASE BY ME WILL BE IMMEDIATELY DUE AND PAYABLE.

MISCELLANEOUS FEES

NO CALL/ NO SHOW APPOINMENTS WILL BE SUBJUECT TO A $20.00 FEE THAT WILL NOT BE CHARGED TO ACCOUNT OR INSURANCE (other patients need an opportunity to receive help.)

ALL RETURN 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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