Patient Intake Date____________

Name:________________________________ Social Sec#:___________________
Address_______________________________ Phone (H)_____________________
City, St., Zip____________________________ Phone(C)_____________________
Date of Birth:______________ Age____ Spouse's Name:_____________________
Employer:______________________________ Phone(W) ___________________
Address:______________________________ Who may we thank for referring you?
City, St., Zip:____________________________ _____________________________
Insurance Carrier:_________________________ Policy #:____________________
Email address____
Is this episode of pain a result of a accident? _____ If yes, when? ________________
How did the accident occur ___Auto Accident ___ On the Job ___ Sports___ Other___
List any previous injuries, accidents, or illnesses including hospitalizations: __________
____

List activities you enjoyed doing prior to your pain that you can no longer engage in due to pain:
____

The information provided is true and correct to the best of my knowledge.

Signature __________________________________ Date:______________________

I authorize release of information necessary to process claims and request payment be made directly to: Atlantic Chiropractic & Rehabilitation.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Atlantic Chiropractic & Rehabilitation will prepare any necessary reports and forms to assist me in making collection from the insurance company, and that any amount authorized to be paid directly to Atlantic Chiropractic & Rehabilitation will be credited to my account on receipt.

I understand that Atlantic Chiropractic & Rehabilitation expects my insurance company to pay/cover the percentage of my services they claim they will cover. However, in the event that my insurance company denies coverage of those services for whatever reason, I understand that I am ultimately responsible for the remaining balance.

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered to me will be immediately due and payable. Any monies paid directly to me or my attorney for medical bills from this office will be immediately paid out to this office. I understand payment is due on my account 30 days from, treatment, after 30 days interest will accrue at 1.5% per month on the outstanding balance. In the event my account is turned over to a collection agency or an attorney, I agree to pay all cost of collection including collection, agency fees and attorney fees at 33 1/3%.

_______________________________ __________
Signature Date