

# PATIENT INFORMATION

File # \_\_\_\_\_

Date \_\_\_\_\_

## Patient Information

Thank you for choosing our practice for your Chiropractic needs. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. If you have any questions or concerns, please ask for assistance. We will be happy to help you. Thank You.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ S/S \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Sex:  Female  Male

E-mail Address \_\_\_\_\_

Are you:  Minor  Single  Married  Divorced  Separated  Widow

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Your Occupation \_\_\_\_\_ Your Employer \_\_\_\_\_

Business Address \_\_\_\_\_ Work Phone \_\_\_\_\_

Spouse or Parent Name \_\_\_\_\_ Workplace \_\_\_\_\_ Work Phone \_\_\_\_\_

Name of person responsible for this account? \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

## Insurance Information

Please provide us with your insurance card so we can make a copy of it for our records.

Name of primary insurance card holder \_\_\_\_\_

Is this visit related to an accident?

Automobile  Yes  No Work Related  Yes  No Other  Yes  No

Date of injury \_\_\_\_\_ Time \_\_\_\_\_ Place \_\_\_\_\_

Please bring us a copy of your accident report.

## AUTHORIZATION FOR PAYMENT / FINANCIAL AGREEMENT

I hereby authorize Brady Chiropractic Group to furnish information to insurance carriers concerning this illness/accident, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. I agree to pay all attorney fees and costs incurred by Brady Chiropractic Group to collect any unpaid balance. I certify the information I furnished is true and correct.

I understand that **BRADY CHIROPRACTIC GROUP, PC** bills my insurance as a service to me. I understand that it is my responsibility to ensure that my insurance carrier processes all claims. I understand that I am personally responsible for all charges whether or not paid by my insurance carrier. Should payment for services performed by **BRADY CHIROPRACTIC GROUP, PC** be paid directly to me by my insurance carrier, I agree to promptly forward such payment to **BRADY CHIROPRACTIC GROUP, PC**.

I agree to pay my deductible, co-pay or co-insurance at the time of service. I agree that if payment is not made in the agreed upon manner I will pay interest on said account at the rate of 1.5 % per month on the unpaid balance (18% per annum). Brady Chiropractic Group offers our non-insurance patients a discount if payment is made at the time of service. (This does not include the initial exam, x-rays, massage, supplements or supports.)

\_\_\_\_\_  
PATIENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS SIGNATURE