HEALING HANDS CHIROPRACTIC REGISTRATION

| Patient Last Name State State Zip | Date | Home Phone Work Phone | | ne | Cell Phone | | |
|--|---|---|-------------------|------------------|------------------|------------|--|
| Street Address | Patient Last Name | First Name | | Init | Initial Email | | |
| State | | | | | | | |
| Social Security # | City | | Stat | e | Zip | | |
| Last Name | | | | ☐ Married ☐ Wido | owed Separated | ☐ Divorced | |
| Last Name | Social Security # | | | | | | |
| Relationship to Insured Condition/Illness Related To Illness Employment Auto Other Condition/Illness Related To Illness Employment Auto Other Company Name | insured Name how and where did you learn about this clinic? | | | | | | |
| Condition/ Illness Related To | | | | | | | |
| Company Name | | | | | | | |
| Address | Condition/ Illness Re | elated To Illness | □ Employment | | to | ☐ Other | |
| Name | | | | | | | |
| Name | EMPLOYER | | | | | | |
| Name | | City | State | Zip | Years Employed_ | | |
| Employer Name | | Name | | Birth date | SSN: | | |
| City State Zip Pull-time Part-time PATIENT Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name Dicy/Group #: Effective Date: Name of Insured: ID #: SPOUSE Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name ID #: Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name Insurance Insurance and/or employee health Care Plan Name Insurance Plan Care Plan Name Pregnant Yes No Pacemaker Yes No Pamily Physician Person to contact in an emergency If you answered yes, please fill out accident specific form, available at the front desk. Person to contact in an emergency Person to contact in an emergency Phone Relationship Insurance Plan Name Phone Relationship Phone Relationship Phone Phone Phone Phone Phone Phone Phone Phone Phone | SPOUSE | | | | | | |
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| Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name Policy/Group #: | | Address | Phone | | Occupation | | |
| INSURANCE INFORMATION Insurance Company or Health Care Plan Name Policy/Group #: | | | | | | | |
| Name of Insured: | | Please list any and all insurance and/or employee health care plan coverage you or your spouse may have | | | | | |
| Name of Insured: | | Insurance Company or Heal | th Care Plan Name | | | | |
| Name of Insured: | INFORMATION | Policy/Group #: | | Effective Date: | | | |
| Insurance Company or Health Care Plan Name Policy/Group #: | | Name of Insured: ID #: | | | | | |
| Policy/Group #: | | | | | | | |
| Name of Insured: ID #: | | Insurance Company or Heal | th Care Plan Name | 77.00 | | | |
| Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? □ Yes □ No Your Initials: □ If you answered yes, please fill out accident specific form, available at the front desk. Pregnant □ Yes □ No Pacemaker □ Yes □ No Family Physician □ Person to contact in an emergency □ Phone □ Relationship □ I have been given a copy of the HIPAA Notice to keep □ LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS □ In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Healing Hands Chiropractic, PLLC. all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care plan any claim, chose in action, or other right I may have to such claim cap the medical expenses incurred as a result of the medica | INFORMATION | Policy/Group #: | | Effectiv | Effective Date: | | |
| personal injury someone else might be legally liable for? \[\begin{align*} \text{ \ yes \ \ \ No \ Your Initials: \] \[\begin{align*} \limits \] If you answered yes, please fill out accident specific form, available at the front desk. \] Pregnant \[\begin{align*} \text{ \ yes \ \ No \ Pacemaker \ \ Yes \ \ \ No \ Family Physician \] Person to contact in an emergency \[\begin{align*} \limits \] Phone \[\begin{align*} \limits \] Person to contact in an emergency \[\begin{align*} \limits \] Phone \[\begin{align*} \limi | | Name of Insured: | 11.1 | ID #:_ | | 1 | |
| MEDICAL AND LEGAL INFORMATION If you answered yes, please fill out accident specific form, available at the front desk. Pregnant □ Yes □ No Pacemaker □ Yes □ No Family Physician Person to contact in an emergency Phone I have been given a copy of the HIPAA Notice to keep LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Healing Hands Chiropractic, PLLC. all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan any claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor an | | | | | | | |
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| right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic | | | | | | | |
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| against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses. | | against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses. | | | | | |
| Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please | | | | | | | |
| advise and disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my | | advise and disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my | | | | | |
| | | assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived. | | | | | |
| | | This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered | | | | | |
| as valid as the original. I have read and fully understand this agreement. | | as valid as the original. I have read and fully understand this agreement. | | | | | |
| | | | | | | | |
| Signature of Insured / Guardian Date | | Signature of Insured / G | uardian | | Date | | |