HEALING HANDS CHIROPRACTIC REGISTRATION

Date_____ Home Phone_____ Work Phone_____ Cell Phone _____
Patient Last Name_____ First Name_____ Initial____ Email _____
Street Address_____
City_____ State_____ Zip_____
Sex □ M □ F Age_____ Birth date_____ □ Single □ Married □ Widowed □ Separated □ Divorced
Social Security #_____
Insured Name_____ how and where did you learn about this clinic? _____
Last Name First Name Initial
Relationship to Insured □ Self □ Spouse □ Child □ Other
Condition/ Illness Related To □ Illness □ Employment □ Auto □ Other

EMPLOYER	Company Name_____ Occupation_____ Address_____ Phone_____ □ Full-time □ Part-time City_____ State_____ Zip_____ Years Employed_____
SPOUSE (PARENT)	Name_____ Birth date_____ SSN:_____ Last Name First Name Initial Employer Name_____ Years Employed_____ Address_____ Phone_____ Occupation_____ City_____ State_____ Zip_____ □ Full-time □ Part-time
PATIENT INSURANCE INFORMATION	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 #:_____ Effective Date:_____ Name of Insured:_____ ID #:_____
SPOUSE COINSURANCE INFORMATION	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_____ Policy/Group #:_____ Effective Date:_____ Name of Insured:_____ ID #:_____
MEDICAL AND LEGAL INFORMATION	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 _____
PATIENT AGREEMENT	**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 benefits claim submissions. I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the 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 with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic 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 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. _____ _____ Signature of Insured / Guardian Date