Registration Form

Date _____Home Phone (____) _____ Cell Phone (____) _____

Work Phone (____)_____Driver's License #_____

E-mail Address_____ Learned about our office how: _____

Patient _____
Last Name First Name Middle Initial

Address _____
Street City State Zip

Sex o M o F Age _____Birth Date _____ oSingle o Married o Widowed o Separated oDivorced

Insured's Name _____
Last Name First Name Middle Initial

Relationship to Insured o Self o Spouse o Child o Other
Condition Related to o Illness o Employment o Auto o Other **Insured's Birth Date** _____

Employer Company Name _____ Occupation _____

Address _____ Phone _____

Spouse Name _____ Birth Date _____

Employer Name _____

Patient Insurance

Primary Insurance Insurance Company Name _____ Phone _____

Group # or Claim # _____ ID # _____

Secondary Insurance Insurance Company Name _____

Group # or Claim # _____ ID # _____

Patient Agreement and Policies:

1. Payment is due at the time of service, unless other arrangements have been made.
2. An insurance contract is between the patient and the patient's insurance company. Therefore, it is the responsibility of the patient to keep the account current.
3. Patients involved in litigation (lawsuits) are, as others, responsible for their services here at the clinic.
4. We reserve the right to bill for missed appointments.
5. Personal cleanliness is requested due to the close interpersonal nature of work.
6. **Smoking is prohibited.**

Assignment and Release:

I, the undersigned, have insurance coverage with _____ and assign directly to Dr. Drassal and Dr. Yost or all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature in all my insurance submissions.

If I do not have insurance, I hereby agree to pay in full for all service rendered within thirty (30) days of receiving a bill from the Chiropractic Clinic. If I do not pay in full, the Chiropractic Clinic may charge a 1.5% interest fee/month and, if collections are necessary, charge a $25.00 collection fee.

I have received and read the Patient Privacy Notice.

_____ _____
Signature of Insured/Guardian Date