Shepherdsville Chiropractic and Rehab ~ Dr. David Dahlkamp, D.C. ~ 149 Highway 44E ~ Shepherdsville, KY 40165 ~ (502) 543-2225

PATIENT INFORMATION

Full Name ______________________ Date of Birth __________ Gender: M F

First Middle Last

Address ______________________ City __________ State ______ Zip ______

Daytime Phone: __________ Evening Phone: __________ Cell: __________

SS# __________ Are you a student? ☐ Yes ☐ No ☐ Full-Time ☐ Part-Time

Your Employer (or School) __________ Your Occupation __________

Employer Address __________ City __________ State ______ Zip ______

☐ Married ☐ Single ☐ Widow(er) ☐ Divorced ☐ Separated

If married: Spouse's Name __________ Spouse's Birth date __________

Spouse's Employer __________ Spouse's Occupation __________

Name and Address of Primary Care Physician ______________________

I hereby give permission for Dr. Dahlkamp d.b.a. Shepherdsville Chiropractic and Rehab to contact my PCP regarding my healthcare.

Patient's Signature ______________________ **Date** __________

INSURANCE INFORMATION (please allow our staff to photocopy your current health insurance card(s) & a photo I.D.)

Do you have insurance? ☐ Yes ☐ No Primary Ins: __________ Secondary Ins: __________

Are you the policy holder? ☐ Yes ☐ No **If no:** Name of Policy Holder __________

Date of Birth of Policy Holder __________ Policy Holder's Relationship to Patient __________

I hereby instruct and direct any and all insurance companies, lawyers, or employers liable for my healthcare benefits to pay by check made out and mailed to:
Shepherdsville Chiropractic and Rehab ~ PO Box 215 ~ Shepherdsville, KY 40165

Or: If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:
__________ **c/o Shepherdsville Chiropractic and Rehab ~ PO Box 215 ~ Shepherdsville, KY 40165**

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I hereby authorize and direct you, my insurance carrier, to pay directly to Shepherdsville Chiropractic & Rehab such sums as may be due and owing this office for services rendered me, both by reason of accident or illness and by reason of any other bills that are due this office and withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident, Worker's Compensation benefits, or any other insurance benefits obligated to reimburse me from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect Shepherdsville Chiropractic& Rehab. I hereby further give lien to said office against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated for by Shepherdsville Chiropractic and Rehab. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

I understand that I remain personally responsible for the total amounts due the office for services rendered. I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for the office to await payments, and they may demand payments from me immediately upon rendering services at their option.
A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case to facilitate collection under this Assignment, Lien and Authorization.

I understand I am ultimately responsible for payment to this office. If for any reason my insurance company should pay me for services received in this office instead of paying directly to Shepherdsville Chiropractic and Rehab, I understand that payment is for services performed here, and I must bring the payment in immediately upon receipt.

I have read and understand the foregoing.

Patient's Signature ______________________ **Date** __________

How did you hear about us? ______________________

(Authorization expires three years from date above)