Laurel Street Chiropractic & Spa
4119 Laurel Street, Anchorage, AK 99508; (907) 248-2848

CONFIDENTIAL PATIENT INFORMATION – PLEASE PRINT LEGIBLY

Please **circle** which doctor you are seeing today. **van Zweeden** **Smith**

First Name _____ MI _____ Last Name _____

Address _____ Home Phone (_____) _____

City _____ State _____ Zip _____ Cell Phone (_____) _____

May we leave a voice message regarding your care? **(Circle One)** Yes No Which Phone? Home Cell Work

May we send text messages regarding your appointment to your cell phone? Yes No

Social Security Number xxx-xx-_____ Date of Birth ____/____/_____ Age _____ Sex: **F** **M**

Marital Status**: (Circle One)** Married Widowed Divorced Single Separated

Occupation _____Employer _____

Office Address _____ Work Phone (_____) _____

Emergency contact person name:_____ Phone (_____) _____

Who may we thank for referring you to our office? _____ Email:_____

CONFIDENTIAL INSURANCE INFORMATION – PLEASE PRINT LEGIBLY

Insured First Name_____ MI _____ Last _____

Relation to Patient _____ Birthdate ____/____/____ Soc Sec# _____/_____/_____

Address if different than patient: _____

Employer _____Occupation _____

ASSIGNMENT, RELEASE AND INFORMED CONSENT

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Laurel Street Chiropractic & Spa all insurance 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 my insurance company. In the event the payment is not made and this account is referred for collection, I will pay the cost of collection. If suit or action by an attorney is instituted, I will pay reasonable attorney fees in said suit or action. Invoice payments will be due upon receipt and are considered past due thirty (30) days from date of invoice, including acceptable lien cases. Interest at the rate of 1.5% monthly will apply to past due amounts. Additionally, I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions and acknowledge receipt of Privacy Notice given to me **(Federal HIPPA Privacy Practices).**

The following information is routinely furnished to all who consider chiropractic care in this clinic. The practice of chiropractic includes many standard examination and testing procedures. These include physical examination, orthopedic and neurological testing, palpation, laboratory tests, radiology examinations, physical therapy and rehabilitative procedures. Additionally, there is a procedure unique to the chiropractic profession - the chiropractic adjustment. A chiropractic adjustment is the application of a quick precise movement over a very short distance to affect the joints of the body by increasing function and range of motion. Chiropractic is a science, which concerns itself with the relationship between structure (mainly the spine) and function (primarily the nervous system) of the body as that relationship may affect the restoration and preservation of health. Our goal is to minimize pain and maximize function by means of the previously stated procedures, inclusive of the adjustment. Chiropractic emphasizes a natural, drug free approach to health and healing.

I am informed and understand that, as in the practice of medicine, the practice of chiropractic has risks in treatment including, but not limited to sprains, strains, fractures, disk injuries and dislocations. I understand these risks are extremely small and that the Doctor's utilize pre-screening procedures and clinical judgment to isolate those persons at high risk.

X _____ **Date**: _____ Patient / Responsible Party Signature