Date:_____________ **Patient Demographic:**

Last Name:	First Name:	MI:
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partnered		
DOB: ☐ M ☐ F	SS #:	
Address:	City:	State: Zip:
Home Phone:	Cell Phone:	Fax:
Work Phone:	Extension:	Professional Title:
(*optional, for promotions*) Email:	How did you hear about us?	
Please circle your preferred method of contact: Cell # / Home # / Work # / Email / Mail		
Would you like us to send you an invitation to our FB Page? Yes / NO		

Employment Information

Employer Name:	Employer Phone:	
Address:	City:	State: Zip:

Emergency Contact:

Contact Name:	Relationship to Patient:	
Home Phone:	Cell Phone:	Work:

Primary Insurance Information

Primary Ins. Company:		
Primary Ins Holders: Last Name:	First:	MI: DOB:
Primary Ins Holders: SS#	Patients Relationship to Primary Holder: Self / Spouse / Child / Other	
Insurance ID #:	Group #:	Plan #:

Secondary Insurance Information

Secondary Ins. Company:		
Secondary Ins. Holders: Last Name:	First:	MI: DOB:
Insurance ID #:	Group #	Plan #:

Insurance & Payment Policies

As a courtesy to you, our office completes and files any necessary insurance forms at no additional charge. Your insurance is an agreement between *you and your insurance company*, <u>not</u> between your insurance company and our office. We offer a complimentary benefits check to verify coverage; however, the benefits quoted to us by your insurance company are NOT A GUARANTEE OF PAYMENT OR BENEFITS.

Occasionally an insurance company will accidentally make payment to the patient instead of the doctor. If this happens, it is your responsibility to send the check to our office after you endorse it and make it payable to Active Life Chiropractic. There is a 20.00 fee for every returned check.

If your treatment is the result of a work related injury or auto accident, full payment for the treatment you receive will be expected regardless if workers compensation or auto claim is denied. It is your responsibility to collect reimbursement from worker's compensation or auto insurance companies

Unless prior arrangements have been made for payment, a 10.00 late fee will occur for balances over 45 days and for every 30 days following until the balance is pain in full.

By signing you understand that you are financially responsible for all charges whether or not paid by insurance. You hereby authorize the doctor to release all information necessary to secure the payment of benefits and are authorizing the use of this signature on all insurance submissions.

I HAVE READ THIS DOCUMENT AND FULLY UNDERSTAND THE POLICIES AND PROCEDURES OF THIS OFFICE.

____

Print:

____

Sign:

____

Date: