

Confidentiality Patient History

Name _____			Today's Date: _____		
Address _____			Birthdate: _____ Age: _____		
City _____	State _____	Zip _____	Marital Status: ___M ___S ___W ___D		
Social Security Number _____			___ Male ___ Female		
Phone Number _____			How many children? _____		
Cell Phone _____			*****		
Employer _____			Spouses Name _____		Spouses Birthdate _____
Address _____			Spouses Employer _____		
City _____	State _____	Zip _____	Spouses Occupation _____		Office Phone _____
Occupation _____	Office Phone _____		Whom may we thank for referring you to our office? _____		

Major complaint _____	Date This Condition Started _____	Caused By _____
.....		

Do You Have Insurance/Medicare? ___ Yes ___ No

Insurance Company Name _____		
Insured's Name _____	Address _____	
Insured's Social Security Number _____	City _____	State _____ Zip _____
Relationship to Insured _____	Group/Policy Number _____	Insurance Company Phone Number _____

Benefits Assigned

I hereby authorize the Clark Chiropractic Clinic to release any information necessary to process this claim. I ASSIGN ALL BENEFITS payable directly to the Doctor and I am financially responsible for all non-covered services.

X _____
Patient's Signature

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I also have been given the Protected Health Information Notice (HIPAA).

I hereby authorize the Doctor to treat my condition as he deems appropriate through the use of manipulation throughout my spine and also understand any risk associated with such manipulation. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

X _____	_____
Patient's Signature	Date
Guardian or Spouse's Signature Authorizing Care _____	_____
	Date