WELCOME TO FREEPORT FAMILY CHIROPRACTIC & ACUPUNCTURE

Patient Information

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ If the reason for your visit today is the result of an accident or work injury, it is very important that you tell an FFCA staff member now.

First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI:\_\_\_\_ Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: F M NB

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

Birth Date: \_\_\_\_\_\_\_\_\_\_ Cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital: M S D W

Cell Provider (for text reminders): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E–Mail Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Receive reminder: text email Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer's Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear of our office? Family/Friend \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \*\*(circle one)**\*\*** Internet/Google Website Facebook/Insta Ins. Co. Other\_\_\_\_\_\_\_\_\_\_

**Chief Complaint – Purpose of this appointment:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies to any medications? Yes No

If yes describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies of any kind? Yes No

If yes describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a pacemaker: Yes No

Pregnancy Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Smoking Status: Never Current Occasional Former

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Financial Policy/Patient Responsibility/Insurance Verification Form**

Name of Primary Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Secondary Insurance Company (if any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your insurance policy is an agreement between you and your insurer, not between your insurance company and Freeport Family Chiropractic & Acupuncture (FFCA). Like all types of care, coverage for chiropractic and acupuncture services varies from insurer to insurer and plan to plan. Most insurance policies require the beneficiary (patient) to pay a co-insurance, co-payment, and/or deductible. For example: if you have a deductible of $500, and your insurance pays 80%, you are responsible for 20% of all charges during the year AFTER your deductible has renewed. (usually at the beginning of the year)

We accept assignments but a quote of benefits is not a guarantee of payment. Our clinic will call your insurer to verify your benefits. However, we are not responsible for your insurer’s final payment and benefit determinations. If a service is not covered that is expected to be covered, the patient agrees to make payment. The office does not offer full write off of a service that was provided.

FFCA has different payment options including: cash, check and credit card; over the phone credit card payments; scheduled auto charges to a credit card and withdrawal from a checking/savings account. . Mailed statements are due within 30 days of being sent to you. Should you want or require a payment plan please speak with one of the FFCA staff. A credit card can be kept securely on file for convenient payment.

**AUTHORIZATION AND RELEASE**: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with physicians and other healthcare providers and payers to secure the payment of benefits. I understand that I am responsible for all costs of care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. Should there be an outstanding balance on your account, the signature of this document authorizes our office to process a payment using the card on file.

**Please Initial One**

A. \_\_\_\_\_ I would like this clinic to bill my insurance. I understand I am responsible for the cost of treatment

B. \_\_\_\_\_ As I have no insurance, I agree to assume all responsibility and keep my account current by paying for services when they are rendered.

Patient's Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian's Signature Authorizing Care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_