SPEER CHIROPRACTIC P.A.

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Patient Information

Please fill out the information below. All forms are kept confidentially within your records.

Today's Date: _____ Patient's Name: _____

Social Security #: _____ Birth date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____Cell Phone: _____

E-Mail Address: _____

To your Email Address: Paperless Billing Statements: Y / N Appt Reminders: Y / N

Employer: _____ Occupation: _____

Marital Status: S M W D Spouse's Name: _____ Birth date: _____

Social Security #: _____ Employer: _____ Work Phone: _____

Children-Names & Ages: _____

How did you hear about us? _____

What is your major complaint? _____

Family Physician: _____ Location: _____

Can we contact them regarding your condition? Y / N

Patient Informed Consent & Acknowledgment

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he deems appropriate. I understand chiropractic adjustment carries some risks. Following are some of the risks: Temporary soreness or increased pain. Other symptoms include dizziness, nausea, stroke and bruising. These symptoms are rare. Disc herniation or prolapse may worsen with treatment. Fractures can occur when patients have underlying conditions. I clearly understand and agree that all services rendered by me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any preexisting medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered by me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctors Office will be credited to my account on receipt. I authorize the Doctor's Office to release any of my records to process the claim.

Speer Chiropractic will ensure that disclosures of Protected Health Information by phone or e-mail are relayed in a confidential and secure manner and are restricted to the minimum necessary to achieve the business purpose.

I understand that voicemail is available to receive messages 24 hours a day. No-Shows inconvenience patients that are in need of our services. A failure to cancel a scheduled appointment without 1-hour notice will be recorded in the patient's file and a cancellation fee of $20.00 will be charged. If you fail to be present for your scheduled appointment you will be charged a "No-Show" fee of $20.00. All fees will be due prior to seeing the doctor at future visits. Further multiple No-Shows may result in suspension of care or termination. Please be advised if you have missed two appointments, we have the right to dismiss you from our care

We understand that some situations are unpreventable and this policy will be considered on the circumstances of the patient.

Signature: _____ Date: _____