

FOR CLINIC USE ONLY

DATE: \_\_\_\_\_

PATIENT INFORMATION

Patient SS#: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

LEGAL NAME: \_\_\_\_\_ Insured: \_\_\_\_\_ DOB: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

Primary Phone: (\_\_\_\_) \_\_\_\_\_ Secondary Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Insured SS# \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Physician: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_ Have you been here before? \_\_\_\_\_

In the event of an emergency, is there someone local that we could contact?

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Daytime/ Cell phone \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Date of Surgery \_\_\_\_\_ Was injury due to Auto Accident? Y / N

Part of Body & Description: \_\_\_\_\_

Frequency & Duration: \_\_\_\_\_ x per Week for \_\_\_\_\_ Weeks / Previous Therapy: (chiropractic, hot/cold pack, US, E-stim, home health, etc. Yes / No How Many/Where: \_\_\_\_\_

INSURANCE VERIFICATION

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Group: \_\_\_\_\_ ID #: \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_ Deductible: \_\_\_\_\_ per Cal Yr Amount Met: \_\_\_\_\_ \$

Coverage: \_\_\_\_\_ \ \_\_\_\_\_ % CoPay : \_\_\_\_\_ Office Visit: \_\_\_\_\_

Visits Allowed per policy: \_\_\_\_\_ per cal yr/per injury/episode/ Auth.# \_\_\_\_\_

Please read and **INITIAL** each of the following : I understand that benefits quoted are not a guarantee of payment. If my claims process different than quoted benefits, I will contact my Insurance Company since my contract is with them and not DSPTC. I am still responsible for any amounts insurance does not pay.

(WC patients: your initials are needed as you are responsible for payment if for any reason your injury claim is denied.)

\_\_\_\_\_ I will pay my deductible, co-pay, and percentage at each visit.

\_\_\_\_\_ I understand that I am ultimately responsible for my account including any amount insurance won't pay. DSPTC will refund any amount due back to me when my account is settled.

\_\_\_\_\_ I understand that DSPTC reserves my appointment time just for me and I will call 24 hours in advance if I need to reschedule.

\_\_\_\_\_ I understand that I will be charged \$25 reschedule fee if I cancel on the same day as my appointment, and \$50 no show fee if I fail to come since this time could not be filled by another patient.

\_\_\_\_\_ I authorized release of my private information to all parties necessary to secure payment and authorize DSPTC to act as my agent.

\_\_\_\_\_ I permit a copy of this authorization to be used in place of the original.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent /Guardian Signature

\_\_\_\_\_  
Date