FORME Medical & Rehab. and Kirk Chiropractic

116 W. Lima St, Findlay, OH 45840 | (419) 425-9798 (p) ~ (419) 425-9698 (f)

Confidential Patient Information

Date: _____

Patients Name: _____ (First Middle Last)

Address: _____

City: _____ Zip: _____

SS#: _____

Date of Birth: _____/ Male____ Female____

Occupation: _____

Work # _____

Home #: _____

Cell # : _____

Email: _____

Marital Status: M S W D **Name of Spouse**_____

Employer: _____

Address of Insured (if different than above): _____

Are your present symptoms or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) ___ Yes ___No

Ins. Company: _____

Ins. Phone #: _____

ID#: _____

Group #: _____

Name of Policy Holder: _____

Policy Holders DOB: _____

Policy Holders Employer: _____

Family Physician: _____City/State they are in_____

Who referred you to our Office?_____

Person to contact in case of emergency _____
Name Phone Relationship

There will be a $40 charge for all appointments that are not canceled 24 hrs prior to scheduled visit.

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to Kirk Chiropractic all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

PAST DUE ACCOUNTS. Our experience has shown that it is important that you understand what happens if you fail to pay for our services. If your account is more than 90 days past due, (1) your relationship with The FORME Medical & Rehab. and Kirk Chiropractic is terminated, (2) your account will be referred to collection, (3) you agree that a "Collection Fee" of $60.00 will be added to the unpaid balance of your account.(4) the unpaid balance will accrue interest at the rate of 1 ½% per month (18% APR), (5) your credit rating may be affected, and (6) you (and the IRS) will receive an IRS Form 1099 for the income you have realized by not paying.(7) Refund checks will be mailed to the patient at their expense (Certified Mail) otherwise they can be picked up in the office.

_____ _____

Signature of Insured / Guardian Date