

A Chiropractic Healing

Please complete all questions. If you need help, please ask us for assistance.

Full Name: _____

Date of Birth: ____/____/____ Sex: ☐ Male ☐ Female SS#: _____

Email address: _____

Mailing Address: _____

Phone #: _____ Are you currently pregnant? ☐ Yes ☐ No

Occupation: _____

Which wonderful person referred you to our office? _____

Emergency contact:
Name and Phone Number _____

Is this visit due to an accident? ☐ Yes ☐ No If yes, what type? ☐ Auto ☐ Work ☐ Other

Date of Accident ____/____/____

I the undersigned, authorize full consent to A Chiropractic Healing (the “facility”), its providers/staff, etc.

I agree to be contacted by A Chiropractic Healing **I grant** the facility and/or its providers/staff permission to use recordings, photographs and/or video of me for any legal use. **I authorize the release** of any medical information, protected health information, and any other information necessary for billing, debt collection(s), reimbursement(s), to process claim(s), or any other related or similar purpose(s). **I authorize to have payment(s)** of medical/healthcare benefits paid directly to the facility/physician/supplier for services. **I agree to pay for services** rendered as charge(s) are incurred. I understand and agree that insurance policies are an arrangement between an insurance carrier and me and I am personally responsible for payment of all services rendered or non-covered. If I suspend, terminate, or discontinue my care/treatment, the fees for services rendered will be immediately due and payable. I understand that if unpaid balance(s) exist on my account after attempt(s) have been made to collect, then my information will be referred to collections and/or legal action will be brought against me and I will be responsible for ANY and ALL reasonable attorney's fees, costs and expenses incurred by the facility/physician/supplier of services.

I agree to “grant” and “convey” a “LIEN” to the facility and its provider(s), if my visits are related to an accident (auto, employment, or other type of accident); to satisfy any outstanding debt obligation(s) owed.

I understand I have the right to revoke authorization(s) at any time; by submitting such request(s) in writing to the facility. I understand that any cancellation of my authorization will be effective when the facility receives my signed request, but it will not apply to information that was used or disclosed prior to that date.

I understand I have the right to receive a copy of authorization(s).

Signature of Guarantor: _____ Date: ____/____/____