WELCOME

Personal Insurance

Thank You for Choosing Us as Your Option for Health

Patient Name_____

Address_____

City/State/Zip_____

Social Security# _____-_____-_____ Gender M F

Date of Birth _____/_____/_____ Age_____

*Marital Status S/M/D/W Spouse Name*_____

Home Phone ( ) _____

Alternate Phone 1 ( ) _____ cell

Alternate Phone 2 ( ) _____ work

e-mail address _____

Emergency Contact _____

Phone Number ( ) _____

Who may we thank for referring you to us?

_____

How did choose our clinic?

☐ Newspaper ☐ Yellow Pages
☐ Location ☐ Attorney

Other: _____

Were you in an Auto Accident? Injury Date: _____

Do you have a work-related injury? Injury Date: _____

Will you be utilizing medical benefits? _____

Occupation _____

Daily activities: _____

Employer _____

Address _____

City/State/Zip _____

Authorization for Care of Minor

I authorize the doctors and staff to perform any necessary services during diagnosis and care of my child

_____

X_____ ____/_____/____
Parent/Guardian's Signature Date

Policy Holder_____

Address_____

City/State/Zip_____

Social Security# _____

Date of Birth ___/___/_____ Home Phone _____

Employer _____

Phone ( ) _____

Address _____

City/State/Zip_____

_____

PAYMENT IS DUE AT THE TIME SERVICE IS RENDERED

ASSIGNMENT OF HEALTH BENEFITS

I authorize the staff to perform any necessary service needed during diagnosis and treatment.
I authorize the release of any medical information necessary to process and pay this claim. I authorize and direct payment of the "Health Benefits," "Medical Reimbursement" from a Third Party Payor, and/or "Government Benefits" otherwise payable to me, directly to:

Jex Chiropractic, P.S.

I understand this office only accepts assignment when insurance pays directly.

X_____ ___/____/____
Patient/Guarantor's or Authorized Signature Date

My Healthcare Benefits

I, _____, fully understand when the insurance company verifies my benefits, **it is not a guarantee or authorization to pay** on claims submitted. I agree to pay my patient portion, plus any balance insurance does not reimburse for, at each visit. I agree to pay/settle any denied and unpaid claims. I further understand all claims submitted by this office are my responsibility and require my participation to settle regardless of my insurance company of assignment of benefits.

X_____ ___/____/____