PATIENT INFORMATION

ATLANTA CHIROPRACTIC & WELLNESS CENTER

Please allow our staff to photocopy your driver's license and all available insurance cards.

WELCOME! PLEASE PRINT.

Full Name _____ Gender: **M F** Home Phone_____

Address _____City_____ State_____Zip_____

Age _____Birth Date _____ Marital Status (Circle One): **S M W D Sep** No. Children_____

SS#_____ email _____

Your Employer _____Your Occupation _____Years on Job _____

Employer Address _____City_____ State _____Zip_____

Work Phone _____ Cell Phone _____

Name of Spouse, Parent or Guardian _____ Age ____ Birth Date_____ SS#_____

Spouse's Employer _____Spouse's Occupation_____Years on Job _____

Employer Address _____City_____ State _____Zip_____

Work Phone _____

How did you find out about our office? _____

Who is your Medical Doctor?_____

Is your condition due to an accident? ☐**Yes** ☐**No** Date of your accident: _____

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. If the doctor is a contracted provider for my managed care pan, I understand I am responsible for all copayments and non-covered services. I also understand and agree to pay all copays and fees for non-covered services prior to seeing the doctor. I understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I understand that unpaid fees for services beyond thirty (30) days are subject to a 1.5% monthly finance charge (18% annually).

I (we) authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of an consequences thereof. I agree that a photostatic copy of this agreement shall serve as the original. I (we) hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a photostatic copy of this agreement shall serve as the original.

Patient's Signature_____ Date _____

Spouse's or Guardian's Signature _____ Date _____