worthington optimal wellness

CONFIDENTIAL PATIENT INFORMATION Date_________

Name:_________________________________ Referred by:__________________________

Address:_______________________________ E-mail ______________________________

_____________________________________ Marital Status: M S W D # of children:______

SSN:_____/_____/_____ Sex M F Occupation:_________________________

Date of Birth:__________________Age:_____ Employer:____________________________

Home Phone:___________________________ Insurance Co.:_______________________

Cell Phone:_____________________________ Ins. Group #:_________Ins. ID #:__________

Work Phone:___________________________ Name of Insured_______________________

E-mail _________________________________ Insuredís Date of Birth:________________________

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___

Family Physician:_______________________________ (Note: We will send health information to this provider.)

Person to contact in case of emergency: Name____________________ Phone No.:_____________

I have reviewed this notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request, I will be given a copy.

Signature___________________________________ Date_____________________________

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 and convey directly to Worthington Chiropractic Center 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 in order to claim such medical benefits, reimbursement or any applicable remedies. 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 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 clinicís 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.

Signature of Insured/Guardian____ Date:___________________________