Simmons Chiropractic Center
Patient Intake Form

Patient Information

Full Name: _____ Date: _____
First MI Last

Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Birth Date: _____ Female: _____ Male: _____

Social Security Number: _____ Email Address: _____

Home Phone: _____ Work Phone: _____ Cell/Other: _____

I prefer to receive calls at (circle) Home/Work/Cell I am (circle) Under Age18/Single/Married/Divorced/Widowed/Separated

Employer: _____ Occupation: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Emergency Contact: _____ Emergency Contact Phone Number: _____

Payment Information

Person Responsible for Payment: _____

Social Security Number: _____ Phone: _____ Date of Birth: _____

Insurance Information

Do you have health insurance? _____ Yes _____ No

Primary Insurance	Secondary Insurance
Insurance Company:	Insurance Company:
Policy Holder's Name:	Policy Holder's Name:
Relationship to Patient:	Relationship to Patient:
Policy Holder's Birth Date:	Policy Holder's Birth Date:
Group Number:	Group Number:
Policy ID Number:	Policy ID Number:

Please have your insurance card and driver's license ready so they can be copied for the clinic's records.

Consent for Treatment

Assignment & Release *- By signing below, I authorize Simmons Chiropractic Center to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to [clinic name] and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*

By signing below, I give my consent for examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient

Signed _____ Date _____

Consent to Chiropractic Services

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, modalities and diagnostic X-rays, on me (or on the patient named below) by the Dr. Jonathan Simmons and/or other licensed Doctor of Chiropractic who now or in the future treat me while employed by, working or associated with or serving as a backup for the Dr. Jonathan W. Simmons, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with Dr. Jonathan W. Simmons or with other office or clinic personnel the scope of practice, nature and purpose of chiropractic care: specialty manual care: i.e., adjustments and other procedures. I understand that with manual care, i.e., adjustments, there is a certain risk of but not all inclusion of: muscle or ligament strains or sprains, bony fractures, cerebral vascular or neurological insult.

I understand and am informed as to the nature and purpose of the procedures, possible alternatives, the risk involved, the possible consequences, and the possibility of complications have been explained to me by Dr. Jonathan W. Simmons and/or his associates and assistants. I do no expect Dr. Jonathan W. Simmons to be able to anticipate all the risks and complications, and wish to rely on Dr. Jonathan W. Simmons to exercise judgment during the course of the procedure which the Doctor feels at the time, based upon the facts then known, is in my best interest.

I authorize Simmons Chiropractic may share information regarding my condition, treatment, and progress with my other health care providers.

Simmons Chiropractic Center / Jonathan W. Simmons III B.S., D.C.

I have read or have been read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below, I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Printed Name: _____

Signature of Patient: _____ Date: _____

Witness/Relationship to Patient: _____ Date: _____

THE FOLLOWING IS TO BE COMPLETED BY THE PATIENT'S REPRESENTATIVE, IF NECESSARY, e.g., IF THE PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED.

Patient's Printed Name: _____

Signature of Patient's Representative: _____ Date: _____

Relationship to Patient: _____

Simmons Chiropractic Center

Financial Arrangement Policy

It is our desire to make chiropractic care affordable to everyone. The established financial policy of this office is that full payment is due at time of service. However, we accept assignment of benefits on most major insurance policies, and also have other options available. Please read the following explanation of our financial arrangements policy and let us know which would be best for you.

Patients without Insurance

If you do know have insurance you may pay at the time of service, or you may use our extended pre-payment plan. The doctor will go over your plan at the time of your second visit.

Patients with Insurance

Health insurance policies are contracts between patients and their insurance companies. However, we accept assignment on most major insurance policies. Therefore, if you have qualifying insurance and sign our "Assignment of Benefits" form, we will prepare and file your insurance claims and wait for up to 120 days (4 months) for insurers to pay their portion of your claims. Under this arrangement you may pay your deductible, co-payments, and non-covered portions on each visit.

If you would like to do so, you may leave your credit card information on file with us. We will process the credit card after every visit for your share of your bill for that date of service. We will notify you by phone and regular mail if you have any balance left over after your treatment is done before we process your credit card. You also agree to notify us of any address changes or card cancellations.

Credit Card # _____

Card Type: _____

Expiration Date: _____

Billing Zip code: _____

I have read, understand, and agree to the above financial arrangement policy.

Patient's Printed Name: _____

Patient's Signature: _____

Cardholder's Name: _____

Cardholder's Signature: _____

Date: _____

Simmons Chiropractic Center

Payment Policies

- Payment is due at time of service.
- Payment for first visit is due at completion of visit.
- You are financially responsible for what your insurance does not cover.
- If there is a balance on your account, you will receive a bill near the beginning of the month, for 3 months total. If we do not hear from you at the end of 3 months you will be sent to collections.
- If you have a balance on your account and cannot pay the total amount, we can make a payment plan for you.

I have read and understand the payment policies.

Patient Name: _____

Signature of Patient or Patient's Guardian: _____

Printed Name: _____

Date _____