

PATIENT INFORMATION

E-Mail: _____
Last Name: _____ First Name: _____ MI _____
Address: _____
City: _____ State: _____ Zip _____

IDENTIFICATION

Social Security#: _____ Sex: M _____ F _____
Date of Birth: _____ Marital Status: S M D W
Family Physician: _____

PATIENT EMPLOYMENT

Employer: _____
Occupation: _____
Phone: _____

Who Referred You? _____

INJURY INFORMATION

What complaint or symptom prompted your visit to the office today?

When did you first notice the problem? _____
Was it caused by: Auto Accident _____ On the job injury _____ Unsure _____
What makes it worse? _____
What makes it better? _____
Have you been treated for this condition? If so, by whom? (doctor, physical therapist, etc) _____

Telephone Numbers

Home Phone: _____
Work Phone: _____
Cell Phone: _____

SPOUSE/PARENT IDENTIFICATION

Name _____
SS# _____
Date of Birth _____
Employer _____
Work# _____

PRIMARY INSURANCE

Insurance Co _____

SECONDARY INSURANCE

Insurance Co _____

PLEASE PROVIDE COPY OF YOUR CARD

CONSENT TO TREAT MINORS

I, _____ acting as parent or legal uardian, hereby grant permission and authorize his/her physician to treat _____ without the benefit of my presence in the office.

The undersigned patient assigns the treating physician the following rights, power and authority:

I request that payment of authorized Medicare benefits or other third party insurance benefits be made either to me or my behalf to Natural State Healing Arts, Inc., for services furnished me by that provider. I authorize any holder of medical information about me to release to Natural State Healing Arts, Inc. or his agents, any information needed to determine these benefits payable for related services. I authorize the release of any and all past and present medical records to Natural State Healing Arts, Inc.. You are assigned to the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for benefits to the extent of your bill for total services if such benefits are owed within the terms of the policy, including the exclusive, irrevocable right to receive payment, and to prosecute and receive penalties, interest, court costs, or other legally compensable amounts owed by an insurance company. I, as the patient and/or responsible party, further agree to cooperate, provide information as needed, and appear as needed to assist in the prosecution of such claims for benefits upon request. To any insurance company providing benefits of any kind to me/us for treatment rendered by my physician, you are hereby tendered demand to pay in full the bill for services rendered by him following your receipt of such bill for services to the extent such bills are payable under the terms of my/our policy for benefits, less any amount which I/we owe personally which are not payable under the terms of your policy. If patient's services for injuries are the result of the negligence of any third party, then patient or responsible party grants a lien against any recovery from such third party (s) to the extent of bills for service, in favor of my physician. Patient waives the right to claim statue of limitations regarding claims for services rendered or rendered by Natural State Healing Arts, Inc. in addition to reasonable costs of collection, including attorney's fees, court costs and interest charges incurred. I understand Medicare may not pay for every treatment received by Natural State Healing Arts, Inc., as Medicare requires treatment to be medically necessary to their reviewers. If Medicare does not pay for said treatment, I understand I will be responsible for payment and that Medicare may not pay for X-rays.

PLEASE INITIAL: _____

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy and, if necessary, diagnostic X-rays, on me by Natural State Healing Arts, Inc. and anyone working in this clinic authorized by Natural State Healing Arts, Inc.. I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including but not limited to, muscle strains/sprains, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor 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 interests. I have read the above consent. I have also had the opportunity to ask questions about its content, and by initialing 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 SIGNATURE: _____