

Lucas Chiropractic Clinic

Patient Information

Today's Date: _____ **Date of Injury:** _____
Reason for your visit today: _____

Statistics:

Patient Name: _____
LAST FIRST M SUFFIX

Current Mailing Address:

PO BOX OR STREET ADDRESS CITY STATE ZIP

Email Address: _____

Employer: _____ **Occupation:** _____

Emergency Contact: _____
NAME PHONE #

Who **referred** you to our clinic? _____

Home (____) _____

Work (____) _____

Cell (____) _____

Which is your primary number? _____

Date of Birth: _____

AGE: _____ **GENDER:** M / F

S.S.N.: _____ - _____ - _____

MARITAL STATUS: M S D W

Who is responsible for this bill?

Name: _____

Phone: _____

Relationship to YOU: _____

Release of Information:

Please list any person who you wish to have access to your personal/billing information:

_____ INT: _____

Please Provide Your Current Insurance Card and Photo ID

Payment Information:

Insurance Coverage? Y/N **Workmans Compensation?** Y/N **Auto Accident?** Y/N

***If you do not have insurance, please see our financial policy for discounts provided if services are paid at the Time of Service.

Primary INS Co: _____ Secondary INS Co: _____

Policy ID#: _____ Policy ID#: _____

Your Relationship to the Insured: _____

Consent to Treatment - I give my consent for examination and the performance of any tests or procedures required. If patient is a minor, by signing I give consent for examination tests and procedures for the above minor patient. By signing below, I verify that the information provided is correct to the best of my knowledge.

Signature: _____ **Date:** _____

Lucas Chiropractic Clinic

Patient Policies

Financial Policy: I understand that I am responsible for all charges incurred at Lucas Chiropractic by myself or others I am financially responsible. I understand that my insurance company will pay for charges according to my benefit plan. I will be responsible for any co-pay, co-insurance, deductible, non-covered items or services deemed not medically necessary by my insurance company. At any time your insurance may request a copy of your medical records, if upon review of those records, they find your treatment to be not medically necessary, you may be responsible for those charges.

If you are unsure of your insurance coverage we will collect 50% at the time of service until your charges are processed by insurance. If at any time an account is overpaid, a reimbursement may be requested- please allow at least 7 business days to process all reimbursements.

Service Pricing: Pricing is based on the current allowed amounts of contracted insurance companies. Pricing is subject to change- however, if at any time those prices change, it will be posted at the front desk of our office. You may request a copy of current pricing at any time.

Insurance Verification: If you are unsure of what your insurance covers, you may call your insurance company directly and ask for the specific benefit. You may also request that we contact your insurance to verify your coverage. *An insurance verification performed by a staff member of Lucas Chiropractic Clinic is not a guarantee of benefits, and is simply a general quote as noted by the insurance company upon calling.*

Time of Service Discount Policy: We offer a Time of Service (TOS) discount to our patients who choose to pay the full amount of their services at the time of their visit. If you choose to accept this discount, no insurance coordination or submittal will be provided by our office. *This discount requires that the payment be made on the same day as you are treated. Any service that is not paid for on the day of service is ineligible for this discount.*

Overdue Accounts: Any patient carrying a balance of more than \$100.00 is required to have a signed payment plan on file. If you do not adhere to the payment plan guidelines, you may be subject to legal action and collections, for which cost you may be responsible. *If your account is past due 90-days and no attempt has been made to resolve the balance, we reserve the right to pursue legal actions.*

Initial: _____

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Massage Cancellation Policy: Due to the scheduling demands of our therapists and clinic, we require a 24-hour notice of cancellation of your scheduled massage. *If you fail to notify us within 24-hours, or fail to arrive for your scheduled time, you will be subject to a \$30.00 cancellation fee per half hour appointment.*

Please note that this fee cannot be billed to insurance companies and must be paid by you personally.

Patient Referral Policy: As a special thanks to our patients, each time you refer a new patient to our office, you will receive a free adjustment. Please tell your friends, to mention your name as their referral! Your name will then be entered onto the referral board to receive a free adjustment the next time you are in! *(Additional services such as massage therapy or physical therapy will be subject to regular rates.)*

Birthday Visits: Because we love our patients, *we offer a free adjustment to existing patients during the month of your birthday.* If it is your birthday month, and you would like to use your free visit, please let the front staff know and we will schedule that for you. *(Additional services such as massage therapy or physical therapy will be subject to regular rates.)*

HIPAA Privacy Practices: We are required by law to maintain the privacy of confidential patient information and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (907)357-6100. If you would like to review the full copy of our HIPAA Privacy Practices please ask the receptionist.

Assignment & Release: *By signing below, I authorize Lucas Chiropractic Clinic to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Lucas Chiropractic Clinic. I agree that a reproduced copy of this authorization will be as valid as the original. 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 state that I understand and hereby agree to abide by these policies.

Signature: _____

Name: _____ Date: _____