Active Chiropractic & Wellness of Chagrin Falls

1 S. Main Street
Chagrin Falls, OH 44022
(440)893-8800
Fax (440)893-9422

Confidential Patient Information

Patient Name: _____ Home Phone: _____ ☐

How would you like to be addressed?_____ Work Phone: _____ ☐

Address: _____ Cell Phone: _____ ☐

Please check preferred phone.

City: _____ Zip: _____ Email: _____

Date of Birth: _____ Employer: _____

Marital Status: M S W D Occupation: _____

Address of insured (if different from above):_____

Who is responsible for this account? _____Phone_____

Person to contact in case of emergency: _____ Phone_____

Are your present symptoms or conditions related to an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) ☐ No ☐ Yes Describe: _____

Family Physician: _____ May we send your health information to this provider ☐ No ☐ Yes

How did you hear about our office? _____

Insurance Company: _____ Ins. Provider Phone #: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder DOB: _____

Policy Holder's Employer: _____

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 at clinic's request, and convey directly to Active Chiropractic 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 any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. 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 the 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 clinic's 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