40 E. Cherry St. Scottsburg 812-752-6202

Patient Information

Patient Name:_______________________________________
(last) *(first)* *(middle initial)*

Address: ____

City: ______________________ State ___ Zip __________

Cell / Home Ph: (_____) _________________ Text Y/ N

Work Ph: (_____) ___________________

Email: ____

Best Contact: Phone Text Email

SS#:________________________ DOB: ______________

Sex: M or F Age: ________________

Status : ☐ Single ☐ Married ☐Widowed ☐Divorced
☐Separated ☐Minor

Occupation: ____

Employer: ____

Spouse
Employer:____

In Case of Emergency

Name: ____

Relationship _______________________________________

Cell / Home Ph: (_____) ___________________

How Did You Hear About Us?

☐ Referral: ____

☐ Internet: ____

☐ Other: ____

What **specific condition** prompted you to choose us?

____

Previous Care

What Type of Treatment have you received?

____

Did it Resolve the Condition: ☐ Yes ☐ No

Primary Care Physician's Name _________________

Clinic Name/Number___________________________

I allow my health progression to be shared with my primary care physician: ☐ Yes ☐ No

Insurance Information

Assignment and Release

I understand and agree that (regardless of whatever health or medical benefits I have), **I am ultimately responsible to pay Health Centered of Scottsburg, INC, Health Centered Chiropractic, Dr. Scott Craig, as well as all employees, employers, representatives, and agents thereof, (hereinafter referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests or medications provided**.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical services rendered and for any supplies, tests or medications that **have been or will be** provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Healthcare Provider all rights to payments and benefits and all legal and other health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or minor dependent) may have under my/our applicable health plan(s) or health insurance policy(ies).

This assignment includes, but not limited to, a designation that Healthcare Provider can act on my/our behalf, as our representative or ERISA representative, as to any initial claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action and/or protect benefits and/or payments that are due (or have previously paid) to Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer, or any administrator. I hereby declare that Healthcare Provider is a my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment and designation remains in effect unless revoked in writing, and a photocopy is to be considered as valid and enforceable as the original.

To the best of my knowledge, the questions on this form have been accurately answered. I understand providing incorrect information can be dangerous to my health. It is my responsibility to inform the office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need. I acknowledge receipt of a copy of the office 'Notice of Patient Privacy Policy'.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Print Name of Patient, Parent, Guardian or Personal Representative

______________________ ______________________
Relationship to Patient Date