CUMBERLAND VALLEY CHIROPRACTIC & WELLNESS

DATE____________________

FIRST NAME__________________________**MIDDLE INITIAL**_____**LAST NAME**___________________________

DATE OF BIRTH______________________________ **AGE**_________ **SEX:**_______________

MARITAL STATUS (CIRCLE) : SINGLE MARRIED WIDOWED DIVORCED OTHER

ADDRESS____

CITY____**ZIP CODE**_______________________

HOME PHONE_____________________________________ **CELL**_________________________________

EMAIL ADDRESS____

EMPLOYER____ **WORK PHONE**________________________

PREFERRED METHOD OF CONTACT: **HOME** **CELL** **WORK**

EMERGENCY CONTACT____**PHONE**________________________

RELATIONSHIP ____

HOW DID YOU HEAR ABOUT US?____
(Please include if referred by a patient, website, insurance company, etc.)

HAVE YOU SEEN A CHIROPRACTOR, PT, OR OCCUPATIONAL THERAPIST THIS YEAR? (circle) **YES** **NO**

<u>This section only needs filled out if you are on Medicare.</u>**

Medicare ID #______________________________________

SECONDARY INSURANCE

INSURANCE NAME____

POLICY ID #____ **GROUP** ______________________________

SUBSCRIBER NAME_____________________________________ **SUBSCRIBER BIRTHDATE**__________________

SUBSCRIBER SOCIAL SECURITY #_____________________________**RELATIONSHIP TO PATIENT**________________

SUBSCRIBER EMPLOYER_____________________________________

By signing below: 1) I consent for myself or my child to receive treatment; 2) I authorize the release of protected health information to insurance carriers and/or their agents for claims payment; 3) I authorize for services to be made directly to Cumberland Valley Chiropractic and Wellness from my primary and secondary insurance. A photocopy of this assignment is considered valid as the original.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL PAYMENTS FOR SERVICES RENDERED INCLUDING DEDUCTIBLE, DO-INSURANCE AND NON COVERED SERVICES. <u>PAYMENT IS DUE AT THE TIME OF SERVICE</u>.

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SIGNATURE OF PATIENT OR GUARDIAN IF UNDER 18 DATE