

Patient Information Form

Name: _____ Date: _____ SSN _____

Address: _____ City _____ State _____ Zip _____

Home phone: _____ Business phone: _____

Birth date: _____ Age: _____ Sex: M F Height: _____ Weight: _____

Business / Employer: _____ Type of work: _____

Check one: Married Single Widowed Divorced Separated

Spouse's name: _____ SSN _____

Spouse's date of birth: _____ Phone: _____

Spouse's Employer: _____ Bus. Phone: _____

Parent's name (if minor): _____ Work phone: _____

Whom may we contact in case of emergency? _____ Phone: _____

Whom may we thank for referring you to us? _____

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Financial Arrangements

Who is FINANCIALLY RESPONSIBLE for this bill? _____

I will be paying today by: CASH CHECK CREDIT CARD

Credit Card # _____ Exp. date: _____

Signature of credit card holder: _____

I hereby authorize to charge my credit card the balance owed if my account becomes delinquent.

Signature: _____ Date: _____

Insurance Information

Type of insurance: Medicare Personal Health Auto Wok. Comp.

Name of insured: _____ D.O.B. _____ SSN: _____

Name of insurance company: _____ Phone: _____

Address: _____ City _____ State _____ Zip _____

Policy # _____ Group # _____

PLEASE SEE REVERSE SIDE FOR COMPLETE FINANCIAL ARRANGEMENTS

Dr. John A. Dennehy, Jr.
Northport Chiropractic Centre
#15 Northport Plaza
Hannibal, MO 63401
573-221-2001

FINANCIAL POLICY

I am committed to providing you with quality chiropractic, acupuncture, and nutrition services at a reasonable price. We except cash, checks and credit cards as a form of payment. In the event that you need extensive care, we work with a finance company that can offer you a six month 0% interest loan. As with any loan you will have to fill out a loan application and be subject to a credit check.

Our office is a Blue Cross / Blue Shield provider only. Therefore, we are unable to except co-pay's from any other type of insurance. What this means for you is that you will be expected to pay for your care at time of service and wait for reimbursement from your insurance company. **We do all of the billing to your insurance company on a weekly basis**, they will send your reimbursement payment directly to you if your deductible has been met.

In our office we offer a vast assortment of therapies that are not covered by insurance, such as: electrical stimulation, inter-segmental traction, myofascial release, therapeutic exercise, acupuncture (with and without needles), and orthopedic nutrition to list just a few. It would be to your advantage to call your insurance company and find out your deductible, if it covers chiropractic health, how much, and what percentage you will be receiving. Our office will supply for you, if necessary, the procedure codes that we use on a daily basis so you can be certain what is covered. **Due to limited time we cannot call your insurance company about benefits for you on the day of service.** It is our office policy to **collect funds for the services provided on the day of service** and then submit all paperwork to your insurance company. You may receive inquiries from your insurance carrier regarding your case. These should be brought to our attention as soon as they are received so we can address any questions your insurance company may have.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, I encourage you to **contact us promptly** for assistance in the management of your account. **Returned checks** and balances older than 30 days may be subject to additional collection fees and interest charges. Should it be necessary for Northport Chiropractic Centre to obtain the assistance of a collection agency or an attorney to collect this account, the patient (or guardian) agrees to pay all costs incurred by Northport Chiropractic in collecting or enforcing payment.

If you have any questions about the above information or any uncertainty regarding insurance coverage, **please** do not hesitate to ask us. We are here to help you.

By signing this form you are acknowledging that you understand this financial policy and that you agree that we may release any information necessary for the processing of your claim to your insurance company, including but not limited to, your name, address, phone number, social security number, date of birth, diagnosis, and treatment dates and services.

Patient Signature: _____ Date: _____