

PATIENT CONFIDENTIALITY PERSONAL DATA

First Name: _____ Middle: _____ Last: _____ Date of Birth: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Social Security No.: _____ Home Phone: _____ Work: _____

Cell: _____ Email: _____ Employer: _____

Contact Preference: Home Work Cell Text Cell Carrier: _____

Occupation: _____ Name of Spouse: _____

SS No.: _____ Spouse Date of Birth: _____ No. of Children: _____

How did you learn of our office? _____

Nearest relative not living with you? _____ Phone: _____

Who is responsible for payment? Self Spouse Other _____

PATIENT'S INSURANCE

SPOUSE'S INSURANCE

Name of Company: _____ Name of Company: _____

ID & Group No.: _____ ID & Group No.: _____

Phone No.: _____ Phone No.: _____

Purpose of this appointment and list your complaints: _____

Date of illness: _____ Time: _____ AM PM Location: _____

How did accident occur? Auto On the job Other _____

Please describe the circumstances and what makes the condition(s) better or worse: _____

Other Doctor seen for this condition: _____ When: _____

Have you been seen by a Doctor for any health condition in the last year? Yes No

If yes, please describe: _____

Assignment of Benefits

I hereby instruct and authorize my insurance company to release information concerning my coverage and benefits for both health/auto insurance and pay by check made out and mailed directly to: Tankersley Chiropractic, 165 Indian Lake Blvd., Suite 102 Hendersonville, TN 37075.

I understand that no guarantees have been made concerning my recovery as every individual responds to chiropractic differently. I hereby authorize Tankersley Chiropractic and whomever they may designate as an assistant to administer therapies and take x-rays if needed.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I authorize Tankersley Chiropractic to release any or all of my medical records as deemed necessary to other health care providers. I also authorize release of records to my insurance company as requested to facilitate payment to Tankersley Chiropractic. I understand this office will take all necessary precautions to insure my privacy. I have been given a copy of the HIPAA regulations for my review.

I have read and understand the office policy stated above and agree to accept responsibility as described.

Patient Signature: _____ **Date:** _____

Parent or Guardian Signature: _____ **Date:** _____

