

*Dr. James Jessen – Dr. Jon Stowe – Dr. John Jordan*

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| **Patient Information** |

Name:

 Last         First MI PREFERRED NAME

Mailing Address:

City, State, Zip Code:

Phone #: ⬜ Cell Phone Email Address:

Would you like to receive appointment reminders via text message?  ⬜ Yes ⬜ No

Would you like to receive billing statements via E-pay? It is an electronic option sent to you via text/email? ⬜ Yes ⬜ No

Date of Birth: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ Gender: ⬜ Male ⬜ Female ⬜ Other

Marital Status: ⬜Single ⬜Married ⬜Widowed ⬜Divorced ⬜Minor

Employer: Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency contact**:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: How did you hear about us?

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| **Accident Information** |

Is this visit due to an accident? ⬜ Yes       ⬜No If yes, what type? ⬜ Auto ⬜ Work  ⬜ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Has it been reported?       ⬜ Yes       ⬜ No If yes, to whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Financial Information (If you are not the subscriber for this insurance, we will need name, DOB, and SS# (if applicable) of subscriber)** |

Do you have health insurance?        ⬜ Yes ⬜ No Name of Carrier:

Name of person who is the policyholder of this insurance:

Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone:

ID # SS#:(AUXIANT/VA ONLY) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Policy Holder’s Employer:

 **PLEASE PROVIDE THE OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)**

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| **Assignment and Release** |

I certify that I (or my dependent) have insurance coverage with the above carrier(s) and authorize, request, and assign my  insurance company to pay directly to Jessen Family Chiropractic, any insurance benefits otherwise payable to me. Should my  insurance carrier not remit payment within 60 days I will be expected to pay my account balance. The contract is between me  and my insurance carrier and I understand I may have to follow up with the insurance carrier regarding unpaid claims. I also  understand that I am responsible for my copay, deductible and coinsurance at the time of service. I understand that I am  financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all  information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure  the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions. This  authorization is in effect until I choose to revoke it.

PATIENT SIGNATURE (X)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE OF PARENT/GUARDIAN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PATIENT FINANCIAL RESPONSIBILITY**

We are pleased to assist you with your chiropractic insurance. If you have medical insurance with chiropractic coverage, please be aware that insurance quotes are an ESTIMATE only. Coverage may be different if your deductible has not been met, annual maximum has been met, or plan benefits have changed. Under your health plan, you are financially responsible for copayments, co-insurance and deductibles for covered services. You are also financially responsible for all non-covered services, including care determined to be elective or maintenance.

Maintenance/Elective care is treatment that does not significantly improve a clinical condition. While being treated for a chronic condition, you may elect to receive care beyond that which is determined to be medically necessary. You may choose to receive maintenance care once maximum benefit from treatment has been reached. If, during the course of Maintenance/Elective Care, you develop a new condition or a previous condition becomes significantly worse, care may no longer be considered Maintenance/Elective and may then be covered by your health plan. Your provider must submit a request for insurance coverage.

By signing below, I acknowledge that I assume full financial responsibility for services rendered to me, if my insurance carrier denies or does not cover my claim for these services. I understand the terms of this form and accept financial responsibility with or without the use of insurance coverage.

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Patient Signature/Guardian Date

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| **Consent for Analysis/Examination/Treatment** |

As part of the analysis, examination and treatment, you are consenting to the following procedures: spinal manipulative therapy, palpation, trigger point massage, range of motion testing, orthopedic testing, neurological testing, muscle strength testing, postural analysis testing, ultrasound, electric muscle therapy, and traction therapy. Any additional procedure required for treatment or analysis will be discussed with you by the doctor at the time treatment is necessary.

 Patient signature Date

**HIPPA NOTICE PROVIDED:**

Initials Date

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| **Authorization to Release Healthcare Information** |

If you would like for someone to be allowed to receive any personal health information about you (any scheduled appointments you may have/had, discussing your healthcare treatment, etc.) please fill in the information below for each person.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize Jessen Family Chiropractic Staff to release personal health information regarding my personal medical records to the following persons:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  Name Relationship to patient

I hereby give my permission for the use of this medical information in the diagnosis and the treatment within Jessen Family  Chiropractic. This authorization will remain active until I choose to revoke it.

 Patient signature Date