The Liebell Clinic: New Patient Information

Name _____ Today's Date _____ Social Security # _____

Age _____ Birthday _____ Sex: ☐M ☐F Address _____

City_____ State _____ Zip _____ Home Phone _____

Work Phone _____ Cell Phone _____ Email (print clearly)_____

Best Place To Reach You: ☐ Home ☐ Work ☐ Cell May we leave a voice mail message for you? ☐ Yes ☐ No

Employer _____ Occupation_____ Length of Employ_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Spouses Name _____

I (signature) _____give consent to Dr. Donald Liebell to speak with me and perform an examination (if necessary), to determine if I am a good candidate to be accepted for treatment.

How Did You Hear About Dr. Liebell? _____

Insurance Information: *If Dr. Liebell accepts you as a patient, it's possible that you may have some insurance coverage for treatment. If you'd like our staff to verify any benefits and extent of coverage, please fill out this section.*

Insurance Policy Holder's # (if other than YOU)_____

Name of Insurance Policy Holder (If not YOU)_____

Relation to Policy Holder: ☐ Spouse ☐ Child ☐ Self Insurance Policy #_____

Is your condition work related? ☐ Yes ☐ No Date of Birth of Insurance Policy Holder_____

Policy Holder sex: ☐ Male ☐ Female Is this condition from an Auto Accident? ☐ Yes ☐ No If YES, what state?____

Name of Policy Holder's employer or school_____ Work Phone #_____

Is your condition related to another accident? ☐ Yes ☐ No

Primary Insurance Plan Name_____ Secondary Insurance Plan Name_____

Name of Insurance Company_____ Insurance Company Phone#_____

Date your policy took effect_____ What is your deductible?_____

Has your deductible been met? ☐ Yes ☐ No ☐ Not sure If NOT, it will be paid by ☐ Cash ☐ Check ☐ Credit Card

Authorization for Care, Insurance Assignment & Fees (If treatment is needed from an auto accident - see separate form)

I understand and agree that my insurance policy is an arrangement between my insurance company and me. I authorize Dr. Liebell to file my claims with my insurance company, allowing any payment to be made directly to him—to be credited to my account on receipt (assignment of benefits). I understand and agree that I am personally responsible for payment for services rendered. I also understand that if I suspend or terminate care, any fees for services rendered me will be immediately due and payable. I hereby authorize the doctor to provide for me examination and treatment. I understand that I am responsible for all fees for service provided at this office including non-covered goods and services, as well as interest (19.3 % A.P.R.) on unpaid balances or debt, collection fees, court fees, attorney fees (33.3%) and all additional costs to this office as a result of any debt. Dr. Liebell will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient Signature_____ Date_____

For Treatment of a Minor: As parent(s) of the patient named above, a minor, I (we) authorize Dr. Donald Liebell to provide examination and treatment:

Guardian or Custodian's Signature Authorizing Care_____

Witness_____ Date_____

Dr. Donald Liebell, D.C., B.C.A.O – 477 Viking Drive Suite 350 Virginia Beach, VA 23452 (757) 631-9799 Fax: (757) 631-9866