Inspire Chiropractic & Wellness

106 South Hanover St. - Hummelstown, PA 17036 - (717) 566-6000

PATIENT INFORMATION

NAME				SOC. SEC. #	
ADDRESS				CELL PHONE	
CITY		STATE	ZIP CODE	HOME PHONE	
BIRTHDATE		SEX: M F (Circle One)		WORK PHONE	
MARITAL STATUS	S M D W	EMAIL ADDRESS			
Preferred phone number?	☐ CELL	☐ HOME	☐ WORK		
EMPLOYER		OCCUPATION			

EMERGENCY CONTACT

NAME		RELATIONSHIP	
CELL PHONE		HOME PHONE	

FAMILY DOCTOR		PHONE	
ADDRESS			

HOW DID YOU HEAR ABOUT US?

☐ Google	☐ Event/Health Fair	☐ Clinic Sign
☐ Website	☐ Facebook	☐ Existing Patient (name)
☐ Dr. Referral		☐ Other (please explain)

AUTHORIZATION AND RELEASE

I consent to treatment necessary for the care of the above named patient.

I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.

For Medicare services, I authorize the release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I allow fax transmittal of my medical records, if necessary.

I acknowledge full financial responsbility for services rendered by Inspire Chiropractic & Wellness, whether or not paid by said insurance.

I understand that payment of charges incurred, including but not limited to copays, multiple copays, and deductibles, is due at the time of service unless other definite financial arrangements have been made prior to treatment.

I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.

I further authorize and request that insurance payments be made directly to Inspire Chiropractic & Wellness.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization. This agreement shall remain in effect until a written withdrawal is served by myself or an agent acting on my behalf.

Signature: _____ **Date:** _____

Revised 5/19