Inspire CHIROPRACTIC & Wellness

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

# NEW PATIENT DEMOGRAPHIC INFORMATION

## PERSONAL INFORMATION

**NAME** _____ **SOC. SEC. #** _____

**ADDRESS** _____ **SEX** M F **MARITAL STATUS** S M D W

**CITY** _____ **STATE** _____ **ZIP CODE** _____ **BIRTHDATE** _____

**CELL PHONE** _____ ***TEXT REMINDERS TO CELL?*** ☐ YES ☐ NO

**HOME PHONE** _____ ***PREFERRED PHONE?*** ☐ CELL ☐ HOME ☐ WORK

**WORK PHONE** _____ **EMAIL ADDRESS** _____

EMPLOYER _____ OCCUPATION _____

## EMERGENCY CONTACT

**NAME** _____ **RELATIONSHIP** _____

**CELL PHONE** _____ **HOME PHONE** _____

## FAMILY DOCTOR

**NAME** _____ **PHONE** _____

**ADDRESS** _____

## HOW DID YOU HEAR ABOUT US?

☐ **Google** ☐ **Event/Health Fair** ☐ **Clinic Sign/Drive By**

☐ **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 physician(s) 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, to appropriate HIPAA-approved parties (insurance, physician, etc).

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

I understand that payment of charges incurred, including but not limited to copays, multiple copays, deductible, and coinsurance, 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.

By providing a phone number, I am agreeing to allow Inspire to leave a voicemail at that number.

By providing an email address, I am agreeing to receive statements by email regarding balances. I am also agreeing to receive occasional updates regarding massage appointment openings and important Inspire updates. (You can unsubscribe at any time.)

Inspire reserves the right to charge a cancellation fee if an appointment is cancelled with less than 24 hours notice or if an appointment is no-showed. This cancellation policy applies to both chiropractic and massage appointments.

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:** _____