1. PATIENT DEMOGRAPHICS

Date:____/____/_____

Name_____

Address_____

_____

City State Zip

Sex: M___ F___ Age___

Birth Date_____/_____/_____

SS #_____

Occupation_____

Employer_____

How did you hear about us? _____

2. CONTACT NUMBERS

Home_____

Cell Phone_____

Work Phone_____

Email_____

3. INSURANCE

We will copy your insurance card, however, we do need the following information.

Are you the subscriber to the insurance?

Yes____ No____

If the subscriber is someone other than yourself, please fill in the following:

Subscriber's Name_____

Relationship_____

Birth Date____/____/_____

4. EMERGENCY CONTACT

Name_____

Relationship_____

Cell_____

Home_____

FINANCIAL AGREEMENT

1) I authorize payment directly to this office of my group insurance benefits. As a courtesy to you, we will submit insurance claims on your behalf. Please realize that insurance companies do not guarantee payment. Therefore you understand that you are personally responsible for all payments on all services.
2) If you are an insurance payment, you agree to first meet your deductible in full and pay your co-insurance or co-payment. We require that you pay your estimated portion of the total fee at the time of service.
3) Your time as well as Dr. Cerefin's is very valuable. If the need arises that you have to reschedule an appointment, please provide us with a courtesy call so that we may have time to contact other patients that may be waiting for that time frame. Failure to notify us within 24 hours of a missed massage appointment will be assessed a $25 fee which will be added to your account. Balances outstanding 30 days are subject to additional collection fees, a $20 late fee, applicable interest charges of 1.5% per month and may be debited to your credit card. Original x-rays and records will remain the property of this clinic.

Signing this document acknowledges that I have read the above information, I understand my responsibilities, and Authorize Cerefin Chiropractic to bill my credit card as outlined above.

Your credit card on file: VISA__ MASTERCARD__ DISCOVER__

Credit Card #_____ EXP DATE____/____/_____

Signature_____ **Date**____/____/_____