



PATIENT INFORMATION

Please allow our staff to photocopy your driver's license and all available insurance cards.

WELCOME! PLEASE PRINT.

Full Name _____ Gender: **M F** Home Phone _____
Address _____ City _____ State _____ Zip _____
Age _____ Birth Date _____ Marital Status (Circle One): **S M W D Sep** No. Children _____
SS# _____ Driver's License # _____

Your Employer _____ Your Occupation _____ Years on Job _____
Employer Address _____ City _____ State _____ Zip _____
Work Phone _____ Cell Phone _____

Do you have health insurance where you work? Yes No Plan/Group # _____

Insurance Company _____

Name of Spouse, Parent or Guardian _____ Age _____ Birth Date _____ SS# _____

Spouse's Employer _____ Spouse's Occupation _____ Years on Job _____

Employer Address _____ City _____ State _____ Zip _____

Work Phone _____

Does your spouse have health insurance at work? Yes No Plan/Group # _____

Insurance Company _____

How did you find out about our office? _____

Describe the major complaints that bring you to our office: _____

Is your condition due to an accident? Yes No Date of your accident: _____

Patient's Signature _____ Date _____

Spouse's or Guardian's Signature _____ Date _____

Financial Options



Thank you for choosing Fish Chiropractic for your healthcare needs. We are committed to providing you the best possible care and are pleased to discuss our fees for service with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees or your responsibility in complying with our financial policy and procedures. The cost of our initial office visit is \$70.00 and due at the time of service. The fees for follow up office visits may vary depending upon the level and type of services needed and may be paid in one of the following ways:

FORMS OF PAYMENT

1. Insurance or 3rd Party Pay

Your insurance policy is a contract between you and your insurance carrier. Our office will file the forms necessary for your claim(s). You may make full or partial payments on your account. Monthly statements will be sent to you that reflect the status of your account. A Credit Agreement is required.

2. Private Pay

You may make full or partial payments on your account. Monthly statements will be sent to you that reflect the status of your account. A Credit Agreement is required.

Credit Agreement

I clearly understand and agree that I am personally responsible for any balance of charges that remain unpaid within 90 days from the time of service.

Name _____ Date _____

Signature _____

3. Non-therapeutic Wellness Care

Patients who are seeking chiropractic care in order to remove interferences to their body's ability to function optimally, thus promoting overall health and wellness may choose this payment option with a special pricing of \$40 per visit when paid at the time of service.

Name _____ Date _____