Welcome

The doctors and staff of Balanced Health and Wellness welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition can be improved by chiropractic care, we will not accept you as a patient, but will refer you to another health care professional, if appropriate.

Patient Acceptance

By providing my signature below, I acknowledge that I understand and agree that the doctors of Balanced Health and Wellness have the right to refuse my acceptance as a patient at any time before treatment begins. Taking a patient's history and performing a physical exam are not considered treatment, but are a part of the process of information gathering to help the doctor determine if he/she can accept me as a patient.

_____ _____

Signature Date

_____ _____

Signature of Guardian or Spouse (If Applicable) Social Security Number

Insurance & Payment

Health and accident insurance policies are an arrangement between the carrier and company. Occasionally it may be necessary for you to provide us with reports and forms to assist us in making collection from the insurance company. Furthermore, any amount authorized to be paid directly to Balanced Health and Wellness will be credited to your account upon receipt.

This office will process your insurance forms upon request. We will do our utmost to provide sufficient information to your carrier in order to obtain payment for your treatment. In some instances, insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. In the event that full payment is not made, or if care is suspended and/or terminated for whatever reason, you must understand that you are immediately responsible to make payment(s) in full. If for some reason your account becomes delinquent, interest will be accrued to your account balance. In the event that professional collection services or attorney action is necessary, you will be held responsible for reasonable and customary charges.

_____ _____

Signature Date

_____ _____

Signature of Guardian or Spouse (If Applicable) Social Security Number

*Signatures denote understanding and agreement of the specifications noted above.

Patient Information

Date:_____

Full Name:_____ Preferred Nickname:_____

Street:_____

City, State and Zip:_____

Telephone: Home:_____ Work:_____ Cell:_____
Date of Birth:_____/_____/_____
[ ] Male
[ ] Female
Social Security Number:_____
Email:_____
Occupation:_____ Employer:_____
Employer's Address:_____
Marital Status (please circle): Married / Widowed / Single / Separated / Divorced
Number of Children:_____
Spouse's Name (if applicable):_____
Name of Minor's Parent (if applicable):_____
Contact in Case of Emergency:
Name:_____ Relationship:_____
Telephone: Home:_____ Work:_____ Cell:_____
Whom may we thank for referring you?
Name:_____
When doctors work together it benefits you. May we have your permission to update your Primary Medical Doctor regarding your care at this office? (please circle) Y / N ?
Name of Primary Care Doctor:_____
Address of Primary Care Doctor: _____

Payment is expected at the time of the visit.
Name or Person Responsible for Payment:_____
Relationship to Patient:_____
Are you Insured?
[ ] Yes (Insurance Company and Group #):_____
[ ] No
Is the Patient Covered by Additional Insurance?
[ ] Yes (Insurance Company and Group #):_____
Subscriber's Name:_____
Birthdate:_____
Relationship to Patient:_____
[ ] No

Remarks or additional information:_____
_____

*The above information is confidential and an important part of our records, so please fill out completely.