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Valley CHIROPRACTIC CLINIC, INC

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Wasilla, AK 99654
92-0139651
Phone: 907-373-2022
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Name: _____ Case: _____ Date: _____
(PLEASE PRINT) (FILLED OUT BY STAFF)

PATIENT INFORMATION

Sex: ❑ *Male* ❑ *Female* Date of Birth (MM/DD/YY): ___ / ___ / ___ Age: ____ SS#: _____-___-_____

Marital Status: ❑ *Single* ❑ *Married* DL#: _____ Spouse Name: _____

Referred By:_____Emergency Contact Name & #_____

Mailing Address: _____ _____ _____ _____
STREET ADDRESS OR POST OFFICE BOX CITY STATE ZIP CODE

Physical Address: _____ _____ _____ _____
STREET ADDRESS OR POST OFFICE BOX CITY STATE ZIP CODE

Phone Numbers: _____ _____ _____ _____
HOME CELLULAR WORK EMAIL ADDRESS

PRIMARY INSURANCE INFORMATION

Insurance Co: _____ Insured ID #: _____ Group #: _____

Insured Name: _____ SS#: _____-___-_____ Sex: ❑ *Male* ❑ *Female*

Relationship of Insured to Patient: _____ Insured Date of Birth (MM/DD/YY): ___ / ___ / ___

Insured Address: _____ _____ _____ _____
(IF DIFFERENT FROM PATIENT) STREET ADDRESS OR POST OFFICE BOX CITY STATE ZIP CODE

Name of Employer: _____ Work Phone Number: _____

SECONDARY INSURANCE INFORMATION (TO BE COMPLETED ONLY IF YOU HAVE ANOTHER INSURANCE PLAN)

Insurance Co: _____ Insured ID #: _____ Group #: _____

Insured Name: _____ SS#: _____-___-_____ Sex: ❑ *Male* ❑ *Female*

Relationship of Insured to Patient: _____ Insured Date of Birth (MM/DD/YY): ___ / ___ / ___

Insured Address: _____ _____ _____ _____
(IF DIFFERENT FROM PATIENT) STREET ADDRESS OR POST OFFICE BOX CITY STATE ZIP CODE

Name of Employer: _____ Work Phone Number: _____

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

Note***: We wish to stress that the financial responsibility for services rendered rests with the patient and his/her family, regardless of any insurance coverage. Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claim. If it is not paid, the insurance company should explain to you why it was rejected. Most of the time our fees fall within their "usual and customary" guidelines; however, the responsibility for the balance of this account falls on you. If any overpayment is received it will be refunded to you. Should your account become 60 days past due, a .008% interest charge can be applied to your account.***

I hereby authorize the release of any medical or financial information necessary to process claims for services rendered.

I authorize treatment of the above named patient and agree to pay all fees and charges for such treatment. I agree to pay all charges when presented with a statement, unless credit arrangements are agreed upon in writing. Charges shown by statement are agreed to be correct and reasonable unless protested in writing within 30 days of the billing date. In the event legal action should become necessary to collect an unpaid balance for medical services to me or my family, I/we agree to pay reasonable attorney fees or other such costs as the Court determines proper.

I understand and agree, regardless of my insurance status, I am ultimately responsible for any unpaid balance on the account.

_____ _____ _____
Patient Signature Date Signed Witness Signature