PATIENT INFORMATION

Name: _____ **Date:** _____
Last First Middle

Address: _____
City State Zip Code

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Employer: _____ **Referred By:** _____

Social Security No: _____ **Birthdate:** _____ **Age:** _____ **Sex:** ☐ Male ☐ Female

Primary Care Physician: _____ **Spouse Name:** _____

Emergency Contact name and Phone No: _____

Email: _____

INSURANCE INFORMATION

All services are considered cash unless full insurance information is provided.

Auto Accident:	☐ Yes ☐ No	**If Yes, Claim No:**	**Date of Injury:**
Work Related:	☐ Yes ☐ No	**If Yes, Claim No:**	**Date of Injury:**
Insured Name: (If other than self)		**Relationship to Above:**	**Insured Birthdate:** (If other than self)
Primary Insurance:		**ID No:**	**Group ID No:**
Secondary Insurance:		**ID No:**	**Group ID No:**

RECORDS AUTHORIZATION

☐ Yes
☐ No **I authorize phone messages may be left on my answering machine.**

I authorize my condition may be discussed with _____
(Spouse/family member, etc...)

CONSENT FOR PAYMENT AND TREATMENT

I authorize my insurance company to make payment directly to Oberg/Larsen Chiropractic in an amount equal to their contracted fee for treatment.
I authorize Oberg/Larsen Chiropractic to release any information pertinent to any insurance company, adjuster attorney to facilitate collection by signing this agreement. I authorize Oberg/Larsen Chiropractic to examine any and all healthcare records pertaining to any injury or condition I am seen for.
In the case of an auto accident or third party accident, I assign Oberg/Larsen Chiropractic any and all insurance benefits, settlement or judgement proceeds due to them, which are or shall become payable to me as a result of my injuries. I agree to see that all charges incurred with Oberg/Larsen Chiropractic are fully paid in the amount equal to their fee for treatment. I grant them an irrevocable lien on those benefits or proceeds for their fees.
I am aware that I am solely responsible for paying Oberg/Larsen Chiropractic for all treatment and services rendered at their office. I understand that at any time they may demand full or partial payment of those services.
I hereby consent to the performance of chiropractic treatment including but not limited to chiropractic adjustment, and diagnostic X-ray by Drs. Oberg and Larsen. I understand that no guarantee or assurance has been given about this treatment.

Patient's signature:	**Date:**
If minor, parent's signature:	**Date:**

MEDICARE DISCLAIMER

To our Medicare patients; We accept assignment on all Medicare patients and chiropractic treatment is a covered service. Exams for chiropractic treatment are a non-covered service with Medicare. Routine maintenance visits are a non-covered service with Medicare. Medicare will not pay for products sold by a Chiropractor (i.e. pillows, braces etc...) Charges not covered by Medicare or your supplemental insurance may become your responsibility. I have read and understand the above.

Patient's signature:	**Date:**