

Weis Chiropractic Health Center
CONFIDENTIAL New PATIENT INFORMATION FORM
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Instructions

The information on this document is kept in your confidential patient file in our office as a record of your office visit.

After printing the document, please fill it out completely. Bring the completed and signed document with you to your office visit. By doing so you'll be able to speed up the initial registration process as a new patient.

CHIROPRACTIC AUTHORIZATION RELEASE & EXPLANATION

CONSENT FOR CHIROPRACTIC TREATMENT

I hereby request and authorize Dr. _____ at Weis Chiropractic Health Center to perform diagnostic tests and render chiropractic adjustments and other treatment. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I Authorize Payment of Any Medical Benefits from _____ to be Paid Directly to This Chiropractic Clinic for Any Service Rendered to Me.

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payments to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to have been made to collect sums due for the insurance company, or companies, contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance companies' proceeds, whether it be all or part of what is due, I personally owe you.
4. I hereby waive the statute of limitations on collection regarding my case and care.
5. I further agree that this Authorization and Assignment is irrevocable until all monies owed are paid in full.

MEDICAL RECORDS RELEASE

KNOW ALL MEN BY THESE PRESENTS: That I, _____, hereby authorize the release of my medical/chiropractic records or copies of the same to such parties the doctor may deem necessary as it relates to my case, and do hereby hold harmless anyone from such actions.

DATE _____

SIGNATURE _____

WITNESS _____