

Hamden Chiropractic
Health & Spine Center
"We help your body heal itself."

Last Name _____ First Name _____ MI _____

Address _____ City _____ State _____ Zip _____

Home () _____ - _____ Work () _____ - _____ Cell () _____ - _____

SSN _____ Email Address _____

Birth Date _____ Age _____ Male or Female Married Single Divorced Other

Employer Name/Phone # _____ Occupation _____

Insurance Company Name _____

Policy Holder's Name _____ Birth Date _____

Relationship to patient *Self Child Spouse Other* Policy # _____

Secondary Insurance Company Name _____

Policy Holder's Name _____ Birth Date _____

Relationship to Patient *Self Child Spouse Other* Policy # _____

Is this condition related to an automobile accident? *Yes No* A work related injury? *Yes No*

I understand and agree that health and accident insurance policies are in arrangement between an insurance carrier and me. Furthermore, I understand that Hamden Chiropractic will prepare and necessary reports and forms to assist me in making collections from my insurance company and that any amount authorized to be paid directly to Hamden Chiropractic will be credited to my account upon receipt.

However, I clearly understand that if my insurance carries does not pay for services rendered to me, I am financially responsible. I also understand that if for any reason my account is sent to collections, an additional fee of one hundred (100) dollars will be added to the amount past due. I attest that the above information is correct to the best of my knowledge.

Signature (guardian) _____ Date _____

Acknowledgement of Receipt of Privacy Practices

I hereby acknowledge that I have received a copy of Hamden Chiropractic Notice of Privacy Practices. I acknowledge that a copy of the current notice is posted in the reception area, and that I may request a copy of any amended Notice of Privacy at each appointment.

Signature (guardian) _____ Date _____