Current Patient Information: 2012

Please fill out the following sheet so we can update our records. Thank you!

Patient Information

Patient Name_____ Date_____

D.O.B._____ SS#_____

_____
address city state zip

_____
email

_____
alt. email

H_____W_____C_____

Emergency Contact_____Phone#_____

Insurance

Insurance Plan_____

Employer:_____

Policy#_____Group#_____

Insurance Phone#_____

*********PLEASE PROVIDE*********
INSURANCE CARD & PHOTO ID

Spouse/Partner Information

Name_____DOB_____

SS#_____Employer_____

Family: related to the contact and insurance information above.

Patient Name_____D.O.B._____ SS#_____

Patient Name_____D.O.B._____ SS#_____

Patient Name_____D.O.B._____ SS#_____

Patient Name_____D.O.B._____ SS#_____

Assignment and Release: I certify that I, and/or my dependent(s), have insurance coverage with above insurance company and assign directly to Drs. Valerie Skow/Juliet O'Donnell all my insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor/facility may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

SIGNATURE **PRINT**

Name of Patient, Parent, Guardian or Personal Representative

HIPAA Privacy

By signing here you are authorizing you have read and understand your HIPAA rights.
Full HIPAA Privacy Disclosure is available at the front desk or online at HeartlandWellnessCenter.com. I authorize detailed voicemail and/or e-mail messages

HIPPA Signature _____ ❒No ❒Yes I authorize Hearland Chiropractic and Wellness Center to leave/send detailed voicemail and/or e-mail messages regarding my appointments, insurance and healthcare with the contact information I provided.

E-mail address: Note: We will now be emailing reminders of your appointments.

HCWC will also use this e-address for patient billing, flexible spending reports, etc. We kindly request 24-hours notice for cancelation of your appointment(s) and information requests ie: flex reports.

Who do you authorize HCWC to provide your private healthcare information regarding your appointment, payments, etc.
parent _____ spouse/partner _____ doctor_____ other_____

Would you like to keep an HSA, Flex or credit card on file with HCWC? Yes No

*This account may be used for: **(circle)** copays coinsurance massage products/supplements

*This account may also be used for the following family members:_____