PATIENT INFORMATION

Full Name ____________________________ Date of Birth ____________ Age_______ Gender: M F

Address _________________________________ City _________________ State _____ Zip __________

Home Phone: ____________________ Work Phone: ___________________ Cell: __________________

SS# ______________________ Are you a student? ☐ Yes ☐ No ☐ Full-Time ☐ Part-Time

E-Mail Address: ____

Your Employer (or School) ______________________________ Your Occupation: _________________

Employer Address ________________________ City ________________ State _____ Zip __________

☐ Married ☐Single ☐ Widow(er) ☐ Divorced ☐ Separated ☐ Life Partner

If married: Spouse's Name ___________________________ Spouse's Birth Date _________________

Spouse's Employer __________________________________ Spouse's Occupation _________________

INSURANCE INFORMATION (Please allow our staff to photocopy your current health ins. card(s) & a photo I.D.)

Do you have insurance? ☐ Yes ☐ No Primary Ins:_________________ Secondary Ins:_____________

Do you have a flex plan? ☐ Yes ☐ No

Are you the policy holder? ☐ Yes ☐ No **If no**: Name of Policy Holder ___________________________

Date of Birth of Policy Holder ______________ Policy Holder's Relationship to patient ________________

I herby instruct and direct any and all insurance companies, lawyers, or employers liable for my health care benefits to pay by check made out and mailed to: **Benton Chiropractic • 112 East 5th Street. • Benton, KY 42025**

Or: If my current policy prohibits direct payment to the doctor, then I herby also instruct and direct you to make out the check to me and mail it as follows:_______________**•c/o Benton Chiropractic • 112 East 5th Street. • Benton, KY 42025**

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I hereby authorize and direct you, my insurance carrier, to pay directly to Benton Chiropractic such sums as may be due and owing this office for services rendered me, both by reason of accident or illness and by reason of any other bills that are due this office and withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident, Workers' Compensation benefits, or any other insurance benefits obligated to reimburse me from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect Benton Chiropractic. I hereby further give lien to said office against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated for by Benton Chiropractic. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

I understand that I remain personally responsible for the total amounts due the office for services rendered. I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for the office to await payments, and they may demand payments from me immediately upon rendering services at their option. **A photocopy of this Assignment shall be considered as effective and valid as the original.**

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case to facilitate collection under this Assignment, Lien and Authorization.

I understand I am ultimately responsible for payment to this office. If for any reason my insurance company should pay me for services received in this office instead of paying directly to Benton Chiropractic, I understand that payment is for services performed here, and I must bring the payment in immediately upon receipt.

I have read and understand the foregoing.

Patient's Signature ____________________________________ Date ______________________

How did you hear about us? ____

Benton Chiropractic • Dr. Joshua A. Adams, D.C. • 112 East 5th Street. • Benton, KY 42025 • 270-527-2007

CONSENT TO TREAT

Patient Name: ____ Date: ___________ Chart #____________

A patient coming to the doctor gives the doctor permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities, or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he is aware that such care may be contra-indicated. It is the responsibility of the patient to make it known or to learn through health care procedures, from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the physician**.**

I understand it is my responsibility to fill out my case history completely and to the best of my knowledge, and to inform the doctor of any information that is not listed on my case history. I also understand that it is my responsibility to inform the doctor of any changes that may occur once I have filled out that information. I authorize Dr. Joshua A. Adams to treat me.

I have read and understand the foregoing.

Patient's Signature ____ Date ________________________

Please inform the receptionist if the patient is under 18; a parent or guardian must sign a consent to treat a minor form.

(Authorization expires three years from date above)