Associated Chiropractics ♦ Dr. Kelsey Roberts ♦ 54 Dwight Ave. Clinton, NY 13323. ♦ (315)-853-6225 ♦ AssociatedChiropractics.com

WELCOME TO OUR OFFICE

Please fill in ALL portions of the form.

Patient Contact Information:

Name:_________________________________Birthday:____/____/____ Age:______ Sex: ☐ M ☐ F
Address:________________________________ City:____________________ State:_________ Zip:_________________
Phone (Cell): (_____)_____________ Phone (Home): (_____)_____________ E-mail:_____________________________

Occupation:____________________________________ ☐ Full-Time ☐ Part-Time
Employer:______________________________________ Location:______________________________________

Emergency Contact #1:________________________Relationship:_____________________Phone: (_____)_____________
Emergency Contact #2:________________________Relationship:_____________________Phone: (_____)_____________

Primary Care Physician/Provider:__________________________________ Location:________________________________
Referred By:________________________________

Insurance Company:__________________________ Group Name/Number:__________________

- I hereby give permission to the doctor to release any information requested by my insurance company acquired in the course of my examination and treatment. I understand that all insurance-related questions be addressed between me and my insurance company.
- I hereby authorize and direct my insurance benefits to be paid directly to the doctor.
- I fully understand that am fully financially responsible for bills/remaining dues on any non-covered services rendered.
- I understand I may be charged for appointments cancelled with no notice or a less than 12-hr notice.
- I understand payment is due at the time of service in the accepted forms: cash, check, and major credit cards.
- I understand that all my accounts put into collection proceedings will have additional collection charged to outstanding chill charges added.
- I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.
- I hereby acknowledge and understand the Notice of Privacy Practices Pursuant to HIPAA and I understand a full copy of this office's HIPAA Compliance Manual is available upon request. I hereby grant consent to the use of personal medical information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA.
- I authorize Associated Chiropractics to contact me by phone or email. Authorization is given to leave a message any answering voicemail inboxes.
- I hereby give permission to the doctor to administer treatment and perform such general procedures as he may deem necessary in the diagnosis and/or treatment of my condition.
- I understand that, chiropractic care/axillary treatments offered in our office, as with any health-care procedures, there are certain complications and risks. I understand further information is available upon request.

Printed Name:____ Date:___/___/_____

Signature:____ Date:___/___/_____