Pinetree Family Chiropractic • 106 Lafayette St. • Yarmouth, ME 04096 • 207.846.9292 (p) • 207.846.9290 (f)

Patient Intake Form

Patient Information

Legal Name: _____ Date: _____
First MI Last

Preferred Name/Pronouns: _____ Social Security Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Birth Date: _____ Sex assigned at birth: M/F Gender identity: M/F/_____

Home Phone: _____ Work Phone: _____ Cell/Other: _____

I prefer to receive calls at (circle) Home/Work/Cell Email Address: _____

I am (circle) Under Age18/Single/Married/Partnered/Divorced/Widowed/Separated/Other _____

Employer: _____ Occupation: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Partner's Name: _____ Partner's Date of Birth: _____

Emergency Contact: _____ Emergency Contact Phone Number: _____

Payment Information

Person Responsible for Payment: _____

Social Security Number: _____ Phone: _____ Date of Birth: _____

Insurance Information

Do you have health insurance? _____ Yes _____ No

Primary Insurance	Secondary Insurance
Insurance Company:	Insurance Company:
Policy Holder's Name:	Policy Holder's Name:
Relationship to Patient:	Relationship to Patient:
Policy Holder's Birth Date:	Policy Holder's Birth Date:
Group Number:	Group Number:
Policy ID Number:	Policy ID Number:

Please have your insurance card and driver's license ready so they can be copied for the clinic's records.

Consent for Treatment

Assignment & Release *- By signing below, I authorize Pinetree Family Chiropractic to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Pinetree Family Chiropractic and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*

By signing below, I give my consent for examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient

Signed _____ Date _____

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Financial Policy

Insurance Coverage

Welcome to Pinetree Family Chiropractic. Your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. Like all types of care, coverage for chiropractic services varies from insurer to insurer and plan to plan. Most insurance policies require the beneficiary to pay co-insurance, co-payment and/or a deductible. For example: if you have a deductible of $100, and your insurance pays 80%, you are responsible for 20% of all charges incurred during the year after you have paid your $100 at the beginning of the year. Our clinic will call your insurer to verify your benefits, however, we are not responsible for your insurer's final payment and benefit determinations.

Payments

In order to help you determine your responsibility toward payment for services, please read the following, and initial your preference for the method of payment of your account. Please notify this office if the status of your insurance changes.

Private Pay: (please initial)

A_____ As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered.

B_____ I have insurance, but I wish to file my claims personally, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered.

Health Insurance: (please initial)

C_____I would like this clinic to bill my insurance. I understand I am responsible for the costs of treatment.

Missed Appointments

It is the policy of Pinetree Family Chiropractic to assess a **$40 missed visit fee** to patients who cancel appointments with less than a 24-hour notice. This clinic provides care for many individuals and missed visits result in time lost that could have been used to provide care for others.

_____ My initials here indicate that I understand the above missed visit policy.

I understand that all health services rendered to me and charged to me are my personal financial responsibility. I understand and agree to the conditions of this policy.

_____ _____

Signature Date