

# FORME Medical & Rehab. and Kirk Chiropractic

116 W. Lima St, Findlay, OH 45840  
(419) 425-9798 (p) ~ (419) 425-9698 (f)

## Confidential Patient Information

Date: \_\_\_\_\_

Patients Name: \_\_\_\_\_  
First Middle Last

Work # \_\_\_\_\_

Address: \_\_\_\_\_

Home #: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell #: \_\_\_\_\_

SS#: \_\_\_\_\_

Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Marital Status: M S W D

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Address of Insured (if different than above): \_\_\_\_\_

Are your present systems or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) \_\_\_ Yes \_\_\_ No

### Error!

Ins. Company: \_\_\_\_\_

Ins. Phone #: \_\_\_\_\_

ID#: \_\_\_\_\_

Group #: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_

Policy Holders DOB: \_\_\_\_\_

Policy Holders Employer: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Were you referred to our office from a Physician Y / N  
If yes, by whom? \_\_\_\_\_ If no, Name of referral? \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_  
Name Phone Relationship

**There will be a \$25 charge for all appointments that are not canceled prior to scheduled visit.**

### LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to Kirk Chiropractic all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

**PAST DUE ACCOUNTS. Our experience has shown that it is important that you understand what happens if you fail to pay for our services. If your account is more than 90 days past due, (1) your relationship with The FORME Medical & Rehab. and Kirk Chiropractic is terminated, (2) your account will be referred to collection, (3) you agree that a collection charge of \$50.00 is added to your account, (4) the unpaid balance will accrue interest at the rate of 1 1/2% per month (18% APR), (5) your credit rating may be affected, and (6) you (and the IRS) will receive an IRS Form 1099 for the income you have realized by not paying.**

\_\_\_\_\_  
Signature of Insured / Guardian

\_\_\_\_\_  
Date