CONFIDENTIAL PATIENT INFORMATION

DATE:______/_____/______

Island Health & Chiropractic ~ 9431 Coppertop Loop NE STE 204 ~ Bainbridge Island, WA 98110
Lucia Vracin, DC

NAME: ____ GENDER: [ ] Male [ ] Female
Last Name First Name Middle Initial

ADDRESS: ___________________________________ CITY:______________State ___ ZIP_______

E-Mail: ____

PHONE: [H] (_____) _____-__________ [W] (_____) _____-__________ [C] (_____) _____-__________

DATE OF BIRTH: ____/____/______ AGE: _____

EMPLOYER: ____________________________ JOB TITLE:_____________________ HOW LONG?_____

ADDRESS: _______________________________________ CITY:________________ State ___ ZIP______

MARITAL: S M D W SEP PARTNER'S NAME: ____

EMERGENCY CONTACT: __________________________________ PHONE:___________________

WHO MAY WE THANK FOR REFERRING YOU TO OUR CLINIC? ____________________________________

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the office of **Island Health & Chiropractic** to release to the insurance company agencies any information requested by the insurance company to process a claim for payment of treatment received from this office. I understand that these records may be faxed, delivered by courier, mailed or e-mailed.

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to **Island Health & Chiropractic** for any benefits available under my insurance policy for treatment, expences incurred at this office. Further, I request that all benefits allowable under my insurance policy be issued directly to **Island Health & Chiropractic**.

I understand that I am financially responsible for all costs incurred in the office, whether my insurance pays or not. I also understand that there may be certain procedures that are not covered by my insurance policy/MVA/Labor & Industries/Third Party accidents, and agree that I will be financially responsible for those charges. Examples of possible non-covered charges: supplies, manual traction, manual modalities, re-exams, exercise instruction, maintenance/palliative care, application of heat/ice. I agree that this Assignment of Benefits is irrevocable and that I am waiving the statute of limitations for payment.

INITIAL ____ **FOR CONSENT TO TREATMENT OF MINOR CHILD**: As parent and/or legal guardian, I have the authority to authorize, and do hereby grant the Chiropractor(s) at **[name of clinic]**, to administer chiropratic care as he/she deems necessary to my son/daughter/ward: __________________________(name of minor)
___________________________________(print adult name).

I understand the Authorization to Release Information, and Assignment of Benefits, and agree to the above paragraphs. My initials above also authorizes the Treatment of a Minor. **By refusing to sign I understand that I and/or my child will not be able to receive care in this office**.

SIGNED: ____ DATE:_____/_____/_____