Sports & Spinal Injury Clinic, LLC

6634 Lake Otis Pkwy #A, Anchorage, AK 99507
Phone (907) 522-3511; Fax (907) 522-8551

Patient Name: ____
Last First Middle

Name You Prefer to be called: ____________________ SS#: ______________________

Date of Birth: ____/____/____ Gender: M / F Email: ______________________

Mailing Address/City/ST: ______________________________ Zip: __________

□Home Phone #: __________ □Cell Phone #: __________ □Work Phone w/ext.: __________

(Please check all box(es) above where detailed messages regarding your appointment or billing issues can be left.)

Occupation: Student / Clerical / Laborer / Education / Sales / Other: ______________

Employer: ______________________________ How long?:__________

Employer's Address/City/ST: ______________________________ Zip __________

Other Phone #'s: ______________ Marital Status: Single / Married / Divorced / Widowed / Separated

Spouse's Name: ______________ Spouse DOB: ________ Spouse Cell #: __________

Spouse's Employer: ______________________________ Phone Wk #: __________

Spouse SS#: ______________ Emergency Contact: ______________

Emergency Contact Relation: ______________ Phone #: __________

I HEARD ABOUT THIS CLINIC FROM (Name if app): ______________________________

Payment (Circle one) **Auto • Cash/Check/CC • Health Ins • MC • Personal Injury • VA • Work Comp**

Do you have Medicare? Yes / No Is Medicare your Primary or Secondary? ______________

Person ultimately responsible for account (If dependant is patient)

Name: ______________________ SS#: ______________ DOB: __________

Mailing Address/City/ST: ______________________________ Zip: __________

Home #: __________ Cell #: __________ Relationship to Patient: ______________

Employer: ______________________ Work # __________-

Primary:

Insured Name: ______________________ SS#/ID: ______________ DOB: __________

Insurance Co.: ______________________ Group #: __________ Plan #: __________

Ins. Address/City/ST: ______________________________ Zip: __________

Phone #: ______________ Insured's Employer: ______________________________

Secondary:

Insured Name: ______________________ SS#/ID: ______________ DOB: __________

Insurance Co.: ______________________ Group #: __________ Plan #: __________

Ins. Address/City/ST: ______________________________ Zip: __________

Phone #: ______________ Insured's Employer: ______________________________

I certify that I'm the patient or legal guardian listed above and consent to the collection and use of the above information to this office of chiropractic. I fully understand when the insurance company verifies my benefits it is not a guarantee or authorization to pay on claims submitted and that health / accident insurance policies are an arrangement between an insurance carrier and myself. I agree to pay my patient portion, plus any balance the insurance does not reimburse for, at each visit or when I receive the outstanding bill. I agree to pay/settle any denied and unpaid claims over and above insurance payments. I further understand all claims submitted by this office are my responsibility and may require my participation to settle regardless of my insurance or assignment of benefits. I also authorize the release of any information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I also understand that if my bill is not paid within 90 days of the date of service and no financial arrangements have been made, a $25 per month charge from the first month will be added to my bill. I agree that this office will file my claim form, and that Health Care Benefits or Medical Reimbursement from a Third Party Payer, if I don't have med-pay with my insurance, will be made directly to **Sports & Spinal Injury Clinic, LLC** otherwise payable to me, unless the account is previously paid in full. I understand that *a discount on liens will/can be accepted only if ALL parties involved accepts the same discount and proof is available, including the **Attorneys***. I authorize **Sports & Spinal Injury Clinic, LLC** to perform any necessary diagnostic testing, ie. vital signs, range of motion, palpation, muscle strength, postural analysis, basic neurological, orthopedic testing, etc., needed during diagnosis and treatment. I understand that pain syndromes can be caused by conditions (such as tumors, etc.) which may be visualized by x-rays, however, I have decided that if the Doctor determines X-rays are not necessary for my condition that I agree also to not have x-rays and do not hold anyone associated with the **Sports & Spinal Injury Clinic, LLC** responsible for such pathology and authorize this office and its staff to examine and treat my condition as the doctors see fit. **I also understand that if I do not show for an appointment or if I give less then 12 hours notice to cancel or reschedule an appointment, that I am responsible for the charges of that appointment and not my insurance**. I have read and understand the included information, certify it to be true and accurate to the best of my knowledge, understand it is my responsibility to inform this office of any changes in my medical status and agree to these terms. I also agree and understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Signature of Patient (or Guardian) ______________________________ Date__________