Springbrook Chiropractic 420 Villa Rd. Newberg, OR 97132

"Life. Realigned!"

Dr. John J. Collins, Chiropractic Physician

PATIENT INTAKE AGREEMENT

Patient Name: _____ Daytime Tel: _____ Cell Tel: _____

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

E-mail: _____ Date of birth: ____/____/_____ Age: _____

S.S.#:_____ Driver's Lic.#: _____ State: ___ Place of Employment: _____

Emergency contact: _____ Tel: _____ Relationship to Patient: _____

How Did You Hear of Our Clinic (circle one or more)? From friend/family member (Please tell us their name so that we may thank them):_____; Saw our Sign ; Yellow Pages; Our Web Page ; Google/Internet Search; Newspaper; Facebook/Social Media; Referred by Another Doctor/Practitioner (name)_____; Found us on List Provided By Employer /Insurance Co.; Other Y/N (please tell us:_____

OUR OFFICE POLICY (updated 08/16): Welcome to our clinic! Thank you for entrusting us to help you with your health. Our goal is to help you restore and maintain your health by providing you with the highest quality of chiropractic care available. Please read and sign. By signing below, you acknowledge that:

1) The patient (or legal guardian) is ultimately responsible for payment of all services. The standard fees for our services are at or below 'usual and customary' fees for similar services in this area. A copy of our fee scale is available for you to take, please ask the front desk personnel.
2) If a patient has insurance that provides significant chiropractic coverage at this clinic (i.e. car injury coverage, group health insurance, managed care plan, worker's compensation, etc.), then we will (upon your request) bill the insurer directly (once we have qualified them). This is called "accepting assignment of benefits" and it is a privilege that we extend as a convenience to patients. Regardless of what your insurance company has quoted you, there is no guarantee of insurance until coverage has been verified by our staff. If we bill an insurance company, the patient is still responsible for any and all co-pays, co-insurance and/or outstanding deductible balances. These payments are to be paid on the same date of service, unless other arrangements have been made. Please inform the staff or doctor if you are unable to pay on the date of service and we will arrange a payment plan.
3) Although this office makes every reasonable attempt to collect the fees that your insurer is liable for, any charges ultimately denied by the patient's insurance company, for any reason, will be transferred back to the patient and the patient is then responsible for those charges (except in cases where this office has signed managed care contracts to the contrary and/or if fees are limited by law [i.e. Worker's Compensation or Personal Injury, etc.]). It is your responsibility to inform us of any changes to your insurance coverage.
4) All patients owing balances will receive a monthly statement. The amount owed is due, in full, at our office by the 'due date' unless other arrangements are made.
5) Our office reserves the right to charge a fee for appointments missed without prior notification.
6) All missed treatments are to be made up in a timely fashion. Failure by patient to adhere to the agreed-upon treatment plan may be cause for dismissal and/or withdrawal of the 'insurance assignment privilege'.
7) You have received a copy of our ROF/PAR/Informed consent policy.
8) Your privacy is of utmost importance to us. Our office complies with all state and federal laws and requirements regarding the protection of patient information.

___ Initial here if you have any questions. ___ Initial here when your question is answered.

Patient/Guardian Signature: _____ Date: ____/____/_____