# ChiroCenter One

## Admittance Form
(Adult version)

Name ________________________________ Date _____/_____/_____ File # _______________
First M.I. Last

Address __________________________________________ City ___________________________

State __________ Zip __________ Home Phone (_____) __________ SSN _____-_____-_____

Gender: ☐ Male ☐ Female ☐ Married ☐ Sgl ☐ Div ☐ Other Birthdate _____/_____/_____

Emergency Contact ___________________________________ Phone (_____) __________

**Referred by:** ☐ Physician ☐ Yellow Pages ☐Patient/Family/Friend ☐Other: ____________________
*** * please provide name if physician/patient**

Employer ________________________________________ Type of work _____________________

Address __________________________________________ City ___________________________

State __________ Zip __________ Business Phone ____________________________________

**Please provide the following payment/insurance information:**

☐ I have no insurance coverage which will pay for chiropractic care.
**I will pay by:** ☐ Cash / Check ☐ Credit Card
☐ I would like to discuss payment arrangements
☐ Blue Cross/Blue Shield of North Dakota:
**I will pay my co-pays by:** ☐ Cash / Check ☐ Credit Card
☐ Other group or private health insurance
☐ Worker's Compensation ➜ **Date of Injury:** ____________________
☐ ND or MN Medical Assistance
☐ No-Fault Auto Insurance ➜ **Date of Injury:** ____________ **State**______
☐ Medicare
☐ Other ➜ please explain (incl. AFLAC): ______________________________________

☐ **I understand that payment/co-pymt is expected upon completion of each appointment unless prior arrangements have been made.**

☐ **I am a student, please send billing to the insurance policy holder.**
(Must complete section below)

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**If you are not the insurance policy holder, then you must complete the following (if plan is in parent/spouse name):**

Name of insured: ________________________ Birthdate: ____/____/_____ Relationship: ______________

Place of employment for insured: ___________________________ Home Phone: (_____) ____________

Employers address: ________________________ Home address: ________________________________

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***I understand that health and accident insurance policies are an arrangement between an insurance carrier and myself (or name of insured), and I understand that I am responsible for payment regardless of what insurance covers.*** *I authorize the release of any medical or other information necessary to process this claim, and I authorize payment of medical benefits directly to ChiroCenter One for services rendered. I also authorize ChiroCenter One to administer such treatment and diagnostic procedures as is necessary, and to perform manipulation, therapy, and/or other procedures considered therapeutically necessary on the basis of findings during the course of treatment. I understand that treatment carries with it the risk of complications, and I also certify that no guarantee has been made as to the results that may be obtained.*

______________________________________________ ____________________
Signature Date

**PAYMENT REQUIRED WHEN SERVICE IS RENDERED ~ VISA & MASTERCARD ACCEPTED ~ THANK YOU**