Serenity Family Chiropractic, P.C.

PM # _____

Name _____ Sex: ❑Male ❑Female Date of Birth ____/____/____

Address _____ City / State _____ Zip _____

Home (__)_____ Cell (__)_____ Who can we thank for referring you to our office? _____

Social Security #_____ ❑Married ❑Single ❑Divorced ❑Widowed ❑Separated

Would you like to receive our monthly chiropractic newsletter? Your email will be used for office communications only.

❑Yes ❑No Email: _____@_____.com

Employer

Employer _____ Occupation _____ May we contact you at work? ❑Yes ❑No

Work (__)_____Address _____ City / State _____ Zip _____

Emergency contact

Name _____ Relationship _____ Home (_____)_____

Cell (____)_____ Work (____)_____ May we contact this person at work? ❑Yes ❑No

Health Insurance Do you have the benefit of health insurance? ❑Yes ❑No

Who carries this policy? ❑Self ❑Spouse ❑Parent ❑Guardian

Please fill in the information below if the insurance policy is through someone other than yourself.

Subscriber's full name _____ Subscriber's date of birth_____

Electronic Health Records *In compliance with requirements for the government EHR incentive program.*

As part of the Electronic Health Records changes, CMS requires us to collect the following information. Your email will be used for the patient portal registration and communications only, unless you give us permission otherwise. Thank you for your cooperation. Preferred method of communication: ❑Phone ❑Email ❑Mail

Email: _____@_____.com

Smoking Status: ❑Every day smoker ❑Occasional Smoker ❑Former Smoker ❑Never Smoked

Race: ❑American Indian or Alaska Native ❑Asian ❑Black or African American ❑White (Caucasian) ❑Native Hawaiian or Pacific Islander ❑I Decline to Answer

Ethnicity: ❑Hispanic or Latino ❑Not Hispanic or Latino ❑I Decline to Answer

Preferred Language _____

Are you currently taking any medications? (This does not include vitamins.)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies? ❑**Yes** ❑**No**

Medication Name	Reaction	Onset Date	Additional Comments

After every visit you can elect to receive a copy of your clinical summary emailed to your patient portal. These summaries include a list of your medications, allergies to medications, test results we have on file for you, and your diagnosis within our office. These summaries are often blank as a result of the nature and frequency of chiropractic care. If you choose to receive your clinical summary after each visit, you must have an email on file.

❑ **I choose to decline receipt of my clinical summary after every visit.**

Assignment of Benefits

_____ **RELEASE OF INFORMATION.** I authorize the release of any information concerning my health and health care services to my insurance companies, pre-paid health plan, or Medicare.

_____ **PAYMENT AGREEMENT.** I understand that there is no guarantee that my insurance companies or pre-paid health plan will cover or pay for any or all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges, which includes co-pays and deductibles as specified in my insurance policy.

_____ I authorize and direct that payment to be made directly to:

Serenity Family Chiropractic, P.C. 10739 Highland Road; White Lake, MI 48386

Payment

Payment is expected at time of service. If you have insurance, your deductible and/or co-payment is due when service is rendered. Desired method of payment: ❑Cash ❑Check ❑MasterCard / Visa

I certify that I am the patient listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment. I also understand that any x-rays taken at this office are the property of Serenity Family Chiropractic, P.C.

_____ _____

Signature Today's Date

Complete this section if the patient is a minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand and agree to the above assignment of benefits and payment information.