



Sports Chiropractic Center

Jeremy Rodgers, DC, ATC
Maureen Thomm, D.C.

333 S. Boulder Rd., Ste 2 Louisville, CO 80027

Welcome to the Colorado Sports Chiropractic Center!

We are happy you have chosen us for your health care needs. To serve you as completely as possible, we ask that you complete the following patient information. With this information we will know more about you as a patient, and we will have the ability to file insurance for you, if it is needed. Thanks for your time and patience in providing this information to us – we realize that you are here because you want to feel better, not because you want to fill out paperwork. We want to help you reach your health care goals, so please be complete with your answers – ***thank you!***

Patient Information

Date _____

Patient _____

Address _____

City State Zip

Sex: M F Age Birthdate

____ Single ____ Married ____ Divorced ____ Separated ____ Widowed

Patient SS# _____

Occupation _____

Employer _____

Employer address _____

Employer phone _____

Spouse's name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's employer _____

Provide the name/ location of your primary care physician:

Whom may we thank for referring you? _____

Insurance Information

Who is responsible for this account? _____

Relationship to patient (self, spouse, etc.) _____

Insurance Co. _____

Group # _____

Subscriber's name _____

Birthdate _____ SS # _____

Is the patient covered by additional insurance? ____ Yes ____ No

Relationship to patient _____

Insurance Co. _____

Group # _____

Accident Information

Is condition due to an accident? Yes ____ No ____ Date _____

Type of accident: Auto ____ Work ____ Other ____

If Work Comp: Claim # _____ Date of accident: _____

Ins. Co. Name: _____

Adjuster: _____ Phone: _____

If Auto: Has fault been established? Yours ____ Other ____
If accident is your fault, please fill out Your Auto Insurance Section; if not, please fill out At Fault Driver's Insurance Section.

Your Auto Insurance Company: _____

Adjuster: _____ Phone _____

Claim # _____

At Fault Driver's Insurance Co.: _____

Adjuster: _____ Phone _____

Policy holder: _____ Claim # _____

If you have an attorney, may we contact him/her regarding your care and payment? ____ Name, number: _____

Contact Information

Home # _____ Work # _____ Cell# _____

Email Address _____

Best place / time to reach you _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Best # to call _____

MISSED APPOINTMENTS:

Unless cancelled **at least 24 hours** in advance, we reserve the right to charge a **\$30.00** missed appointment fee. We have voicemail available 24 hours a day, 7 days a week should you need to cancel during non-office hours. We may have patients waiting for an appointment on a cancellation list; your courtesy of a phone call allows us to schedule them. This charge is not covered by or billed to your insurance. Your signature indicates that you understand our policy.

Signature _____ **Date** _____

SUPPLIES AND EQUIPMENT:

I agree to pay for physical therapy supplies, orthotics , braces or equipment in full on the date of service. If these items are specifically covered under my health insurance, I understand that I will only be reimbursed the amount of money paid to Colorado Sports Chiropractic Center by my insurance. I understand that Colorado Sports Chiropractic Center does not have a contract with my insurance company to provide supplies, orthotics, braces, equipment or any durable medical goods.

Signature _____ **Date** _____

RELEASE OF INFORMATION:

I do/ do not (please circle one) authorize any other healthcare providers to release my medical records, x-rays, or reports to Colorado Sports Chiropractic Center for the purpose of obtaining medical information pertaining to my treatment.

Signature _____ **Date** _____

ASSIGNMENT OF BENEFITS:

I hereby assign payment directly to Colorado Sports Chiropractic Center, who represents this clinic to payor groups for the basic benefits, as well as major medical benefits herein specified and otherwise payable to me, but not to exceed the regular charges for this treatment period. I understand that if my injury is due to a motor vehicle accident and the medical benefits are exhausted as such that financial responsibility reverts to my health insurance. I am financially responsible for any applicable deductibles or co-pays. I also understand that I am financially responsible for any charges not covered by this assignment; including denials due to failed attempts to pre-authorize care. Patients may incur a \$10 “claims resubmission” charge should a properly submitted claim be denied, lost, or incorrectly processed by your insurance. I understand that I will be held responsible for any costs incurred regarding collection of payment for services rendered. I will update billing information as soon as any changes occur in my insurance coverage, address or contact information.

Signature _____ **Date** _____

ACKNOWLEDGEMENT OF RECEIPT OF OUR PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided with a copy of the Notice of Privacy Practices and have, therefore, been advised of how health information about me may be used and disclosed by Colorado Sports Chiropractic Center and how I may obtain access to and control of this information.

Signature _____ **Date** _____