

Patient Information

Welcome!

The doctors and staff of **Quatro Chiropractic** welcome you to our office! We are committed to providing the best quality conservative spine care possible. A thorough history and examination will be taken to help us design a treatment plan specific to your healthcare needs, and a report will be sent to your primary doctor. To help facilitate your care, please provide us with the following information:

Demographic Information

Name: _____ Date of Birth: ____/____/____
Address: _____ SSN: ____/____/____
City/State/Zip: _____ Age: _____
Home Ph: ____-____-____ Marital Status: M S D W
Work Ph: ____-____-____ Employer: _____
Cell Ph: ____-____-____ e-mail address: _____

Emergency Contact: _____ Phone: ____-____-____
Primary Care Physician: _____
Referred By: _____

Insurance Information

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Blue Choice | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Blue Cross / Blue Shield | Policy Number: _____ |
| <input type="checkbox"/> MVP | Policy Holder: _____ |
| <input type="checkbox"/> Medicare | Policy Holder's |
| <input type="checkbox"/> Secondary Insurance: _____ | Date of Birth: ____/____/____ |

Payment Agreement and Explanation of Benefits

It is important that you understand your benefits and how they apply to the cost of your healthcare in this office. Please take the time to review this information and to ask the staff or doctor **any** question that you may have.

Co-Payments:

My co-payment is \$_____. This co-payment is due and payable when care is rendered.

Deductible:

Many insurance policies have deductibles. If this visit is applied to your deductible, you will be responsible for the balance at the time of care or within 30 days of being billed. Delinquent accounts may be subject to an additional billing fee of \$2.00 per bill as well as interest, penalties and collection fees after ninety (90) days.

Confidentiality:

We will keep **all** information contained in your file confidential. **No** information will be released unless **expressed written permission** is given by you or your guardian. There are no exceptions to this rule. See our posted privacy policy for details.

Assignment of Benefits:

By signing below the patient authorizes the release of any medical or other information necessary to process claims. This also serves to authorize payments of benefits to Dr. Quatro or Dr. Voelkl as assignment of benefits.

Financial Arrangements:

In cases of financial hardship, arrangements with the doctor can be made to help make your care more affordable. If you are experiencing financial hardship, please speak to someone on the staff or the doctor to make these arrangements.

Patient or Guardian Signature

Date