Fey Chiropractic Thousand Oaks Spine & Injury Center

Chiropractic and Sports Medicine

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name _____ First _____ M.I. _____

Address _____ City _____ State _____ Zip _____

Cell Phone (___)_____ Home (___)_____ Work (___)_____

Date of Birth _____ Social Security No. _____ - _____ - _____

Sex: M / F Marital Status: Single / Married / Divorced / Widowed

E-Mail address _____

Who may we thank for referring you _____

EMPLOYER INFORMATION

Patient's Occupation _____

Employer Address _____

Employer Phone (___)_____ If Student, School _____

SPOUSE INFORMATION

Spouse's Name _____ Date of Birth _____

Spouse Phone _____

INSURANCE INFORMATION

Who is responsible for this account _____

Relationship to Patient _____ Phone (___)_____

Insurance Company _____

ASSIGNMENT AND RELEASE FOR INSURANCE

I certify that I (and my dependents) have insurance coverage with the above company and assign directly to Pierre Fey, D.C., Fey Chiropractic, Thousand Oaks Spine & Injury Center, all insurance benefits, if any, payable for services rendered. I understand that I am fully financially responsible for charges that my insurance company will not cover if they say that an office visit, procedure or treatment is "not medically necessary", "pre-existing", "deductible", or other related reason for non-payment. I also understand that what my carrier considers "non-medically necessary" may, on the contrary, be considered medically necessary by this office and its doctors. Therefore, I agree to hold Pierre Fey D.C., Fey Chiropractic, Thousand Oaks Spine & Injury Center harmless for any medical decisions made by my insurance/managed care carrier which may in any way compromise my best care and result in medical damage, loss or death. I authorize to release pertinent medical information to my insurance company when requested to or to facilitate payment of a claim. Your signature at the end of this document acknowledges you understand this and authorize this office to submit and collect from insurance for services rendered.

INITIAL YOU HAVE READ THE ABOVE: _____

****If you have your card please hand to front desk for a copy and skip to emergency contact**

ID# _____ Group # _____

Insurance Phone (___)_____ DOB of subscriber _____

EMERGENCY CONTACT

Name _____ Phone (___) _____

Name _____ Phone (___) _____

~ TURN OVER ~

ACKNOWLEDGMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

FINANCIAL POLICY

As a courtesy, this office will bill your private health insurance if you have Chiropractic or Physical Therapy benefits. If previously requested, our office will pre-verify benefits for coverage.
****All insurance companies clearly state that even with a verbal, written or online verification of benefits, you are never guaranteed coverage. Ultimately it is the patient's responsibility to know and understand their own insurance policy, co-pays, coinsurance, deductible, pre-existing.**

- It is the patient's responsibility to provide accurate and complete personal and insurance information.
- We are not a participating provider for Medi-Cal or HMO policies.
- All applicable co-pays, coinsurance, deductibles, and personal balances (current and prior) are due at the time of service.
- If you do not have insurance coverage all balances due must be paid at the time of service.
- Payment can be made by cash, check, Visa, MasterCard or AMEX.
- There will be a charge of $35.00 for all returned checks.
- There will be a charge of $30.00 charge for a cancelled massage or missed massage appointment without a 24- hour cancellation.
- Insurance processing can take up to 2 years. You, the patient, are always responsible for any services that insurance denies. Our office will bill, re-bill and appeal on your behalf. If the insurance service is denied you are ultimately responsible for all services rendered.
- All accounts that are sent to collections or included in bankruptcy will be discharged from this office and not permitted to return as a patient. There will be additional collection agency fees and service fees beyond your original balance if you are sent to collections.
- Auto Accident and 3rd party checks need to be endorsed within 30 days of receipt. 18% finance charge will be incurred each month for non-payment.

ACKNOWLEGMENT AND SIGNATURE

I understand, and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand the Pierre Fey D.C., Fey Chiropractic, Thousand Oaks Spine &Injury Center will prepare any necessary reports and forms to assist me in billing my insurance. I authorize this facility to be paid directly and if I receive any payment will endorse the check directly upon receipt back to this office. I acknowledge the above financial policies and understand them fully.
I hereby authorize this facility to examine and treat my, and my dependents, conditions deemed appropriate through the use of chiropractic and physical medicine modalities. I give authority for those procedures to be performed on myself and my dependents. All digital X-Rays will remain on the server in this facility unless requested by the patient. Patient may obtain copies of all records, reports and X-Rays upon request. Copy fees may apply.

I recognize that the practice of chiropractic and physical therapy is not an exact science, and Pierre Fey D.C., Fey Chiropractic, Thousand Oaks Spine & Injury Center and all of its associates do not guarantee the results of treatment.

Patient Signature_____ Date _____

Minor Name_____ Date_____

Authorization to treat Minor, Parent or Guardian Signature_____