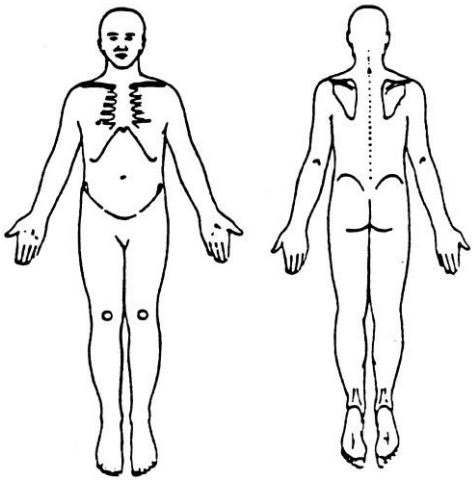
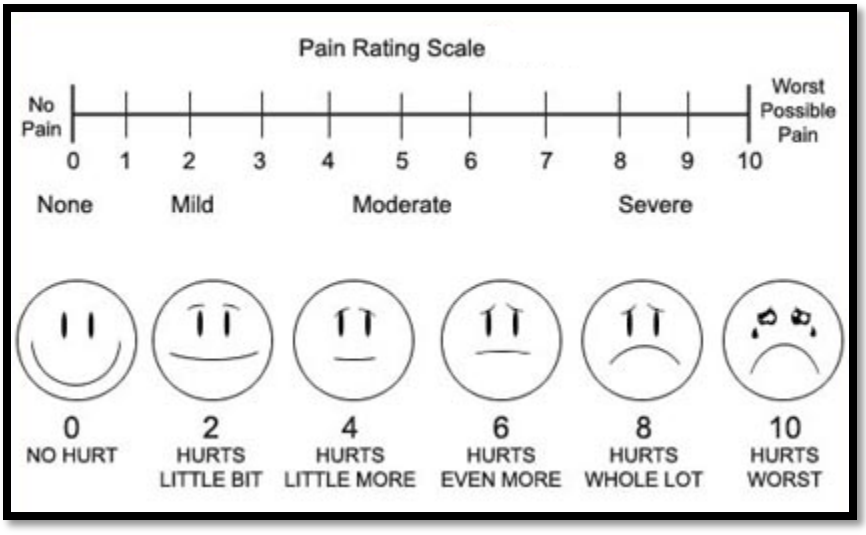
WELCOME TO
OUR OFFICE

Atlas Family Chiropractic · 1255 Boyson Loop Hiawatha, IA 52233·
Phone:319-393-7744 · Fax:319-393-1035

PATIENT INFORMATION	DATE / /
Employer:	**INSURANCE INFORMATION**
Address	Please present your insurance cards and photo ID.
City/State/Zip	Policy Holder Name:
Occupation:	Birthdate: / / Self □Spouse □Child/Dep.
Work Phone:	
EMERGENCY CONTACT	**REFERRAL** How did you find our office?
Relation: Contact Phone:	Phonebook □Insurance □Internet □Location □Mailing □Sign □Patient, their name? _____
RESPONSIBLE PARTY	**ACCIDENT INFORMATION**
Name:	Is condition result of an accident? YES NO
Relation: Phone:	If Yes (Work, Auto) please ask for additional forms.
PATIENT HISTORY	**PAST HISTORY**
Where is your pain?	Have you had any fractured bones? □YES □NO
	Where? When?
Mark any symptoms that you currently have:	Have you ever been hospitalized? □YES□NO
□Headaches □Nausea □Difficulty walking	Are you pregnant? □YES □NO
□Neck pain □Upper back pain □ Joint pain	Do you have abnormal menstrual problems? □YES □NO
□Jaw pain □Low back pain □ Stiffness	List ALL past surgeries or procedures and approx. year:
□Shoulder pain □Leg pain □ Muscle spasms	
FAMILY HISTORY	Mark any diseases you have had below.
□Cancer □Clotting Disorder □Dementia	□Anemia □Heart Disease □Arthritis □Pneumonia
□Diabetes □Gastrointestinal □Heart Disease	□Measles □Mumps □Epilepsy □Influenza
□High Cholesterol □Hypertension □Kidney Disease	□Mental disorder □Diabetes □Rheumatic fever
□Lung Disease □Osteoporosis □Psychological Disorder	□Eczema □Whooping Cough □Cancer □Alcoholism
□Septicemia □Stroke □Sudden Infant Death Syndrome	□Tuberculosis □AIDS/HIV □Venereal Disease
Description:	
Family Member Relationship:	

Indicate areas of pain on the diagram below





Please do not hesitate to ask about fees. We will be glad to file insurance claims at no charge.

You are responsible for any balance not paid by your insurance company.

IF NO INSURANCE: Payment is due when treatment is given.

INSURANCE: Deductibles, co-payments, and non-covered services are expected to be paid at the time of service or at the end of each month. It is your responsibility to provide us with the proper insurance card. If you discontinue treatment, any charges are immediately due and payable.

TREATMENT PERMISSION: I understand that I am responsible for all charges whether or not paid by any third party. I agree that all charges are payable, collectible, and prosecutable in Linn County. If I do not make payment on my account after it is 90 days past due, the account may be turned over for collections and I may be charged the cost of collections. All portions of any bill sent to me by Atlas Family Chiropractic shall be assumed valid unless disputed in writing within thirty (30) days of receiving the bill.

ASSIGNMENT OF RIGHT TO PAYMENT/LIEN AGAINST BENEFITS: I authorize Atlas Family Chiropractic to file my insurance claim. I assign them my right to receive any and all payments or recoveries from any insurance company, attorney, or third party for professional services rendered by Atlas Family Chiropractic. I convey a lien against any funds and authorize and direct any third party to withhold sums from any benefits, judgments, verdict, settlements or recoveries, and to adequately protect and to make payment for these services directly to Atlas Family Chiropractic pursuant to this assignment and lien.

LIMITED RELEASE OF MEDICAL INFORMATION: I authorize Atlas Family Chiropractic to make inquiries and to release any pertinent information to any insurance company, adjuster, or attorney to facilitate collection under these assignments.

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received a copy of the Notice of Privacy Practices.

AUTHORIZATION: By signing below I am agreeing to the terms listed above as well as giving my permission and consent for treatment given by Atlas Family Chiropractic.

PRINT NAME:_____ SIGNATURE:_____ Date_____