NEW PATIENT FORM

RESULTS CHIROPRACTIC

Results Chiropractic Patients:
We have recently updated our systems and need all information below updated. Even if you have been a patient for some time, we need to make sure all information is correct. If you could please take the time to fill out ALL information it would be greatly appreciated.

First Name: _____ M.I.: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Phone (Home): _____ Phone (Cell): _____

D.O.B: _____ Social Security Number: _____ - _____ - _____

INSURANCE - IF YOUR INSURANCE HAS NOT CHANGED PLEASE CHECK THIS BOX ☐

Insurance Carrier: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

ID #: _____ Group #: _____

INSURED

First Name: _____ M.I.: _____ Last Name: _____

Sex: M ☐ F ☐ D.O.B: _____ Social Security Number: _____ - _____ - _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Cancelling an appointment with insufficient notice prevents us from scheduling that time slot for other patients. All cancellations must be made at least 24 hours in advance. Cancellations not made within 24 hours of the appointment will be billed at the rate of $15 unless it is determined by both of us that an unavoidable emergency has occurred. If you do not show up or forget about a scheduled appointment, you will also be billed at this rate since the time was reserved strictly for you.

Please note: if insurance is paying for any portion of your sessions, you will be personally responsible for the agreed upon fee. Insurance will not pay for cancellations or no-shows. We ask that you make every effort to show up for scheduled appointments or give us a minimum of 24 hours notification when appointments need to be cancelled or reschedule.

By signing below, I verify that my information above is correct. I authorize release (if needed) of any information necessary to process my insurance claims. I assign and request payment directly to my physician(s).

Signature: _____ Date: _____