BODYWORKS
CHIROPRACTIC CENTER
DR. THERON HALL 801-302-0301

NEW PATIENT REGISTRATION

Date of First Visit ______________________

First Name ______________________

Last Name ______________________

Address ______________________

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City/ State ______________________

Zip code ______________________

Mobile phone (   ) ______________________

Mobile Carrier ______________________ (verizon/ sprint)

Home phone (   ) ______________________

E-mail address ______________________

Birth date / /

Gender Male / Female

Marital Status Single / Married / Widowed

Soc. Security # / /

HOW WERE YOU REFERRED?

Dr. Hall / Our Sign / Walk-in

Facebook / Our Website / Ad or flyer

Internet Search ______________________

Friend or Family ______________________

Insurance ______________________

Health Fair ______________________

PARENT or GUARDIAN

Parent Name ______________________

Parent Phone

Permissions
List the names of all who are allowed to have access to the personal health records for this patient who is a minor:

PERMISSION for INSURANCE VERIFICATION

I give permission for Bodyworks Chiropractic to verify my insurance coverage and understand that **verification of benefits is not a guarantee of payment.** If I choose to use my insurance I agree to pay my portion as determined by my insurance plan after claim processing. If insurance does not cover services received, I agree that I am ultimately financially responsible to pay for services. If I have any questions regarding my insurance coverage and benefits, or claims processed I will contact my insurance company directly.

X______________________ ______________

Signature of Patient or Guardian Date signed

INSURANCE INFORMATION

Primary Ins: ______________________

Member ID: ______________________

Group #: ______________________

Verification: (leave blank for office staff)

Effective Date: ______________ Year: ________

Deductible: ______________ Met: ________

Family Ded: ______________ Met: ________

Out of Pocket: ______________ Met ________

Coinsurance: ________ after ded. Co-payment: ________

Visits allowed: ______________ or Payout: ________

Pre-auth Required: ______________________

Services included: ______________________

PAYMENT AGREEMENT

I understand that all cash payments, deductible amounts, co-insurance, and co-pays are due at the time of service. I understand and agree that I am ultimately personally financially responsible to pay for all services rendered to me and/or my dependent(s). This may include services billed to insurance and not paid, services not covered by insurance, and any finance charges that accrue. I may elect to bill my insurance, and I am aware that insurance companies may deny claims for various reasons including pre-existing condition clauses, medical necessity, and authorization limits. I am ultimately responsible to track coverage and visits, and am responsible for all charges should services exceed the number allowed by my insurance.

X______________________ ______________

Signature of Patient or Guardian Date signed