GARBERG CHIROPRACTIC

325 Wellsian Way, Richland WA 99352
Gib D. Garberg, D.C. - Ben McIntosh, D.C.

PATIENT INFORMATION (please print)

Name: ______________________ **Date:** __________
Last First (Legal) Middle Maiden

Address: ______________________
City State Zip Code

Birthdate: __________ **Age:** __________ **Sex:** ☐ Male ☐ Female

Home Phone: __________ **Cell Phone:** __________ **Employer/ Occupation:** __________

Spouse Name: __________ **Emergency Contact Name/Phone No.:** __________

Primary Care Physician: **Referred By:**

Text /Email Reminders

I Authorize ☐ **Text Cell Phone Carrier :** **(Circle ONE cell phone carrier for text reminders)**

AT&T Boost Mobile Cricket Metro Pcs Nextel Sprint

T-Mobile U.S. Cellular Verizon Virgin Mobile Other:__________.

Or ☐ **Email Reminders * Email:**__________.

Patient Signature:

☐ **I decline Text/Email Reminders Patient Signature:** __________.

INSURANCE INFORMATION

****All services are considered cash unless FULL insurance information is provided.**

Insured Name:	**Relationship to Patient:**	**Insured Birthdate** (If other than self)
Insurance Co :	**Insurance ID #:**	**Group ID No.:**
Insured Name (If other than Self)	**Relationship to Patient:**	**Insured Birthdate** (If other than self)
Insurance Co :	**Insurance ID #:**	**Group ID No.:**

Per your Insurance Company Policy/Contract **Copays are Due at EACH TIME OF SERVICE**

CONSENT FOR PAYMENT AND TREATMENT

I authorize my insurance company to make payment directly to Garberg Chiropractic, in an amount equal to their contracted fee for treatment. I authorize Garberg Chiropractic to release any information pertinent to any insurance company, adjuster attorney to facilitate collection by signing this agreement. I authorize Garberg Chiropractic to examine any and all healthcare records pertaining to any injury or condition I am seen for. In the case of an auto accident or third party accident, I assign Garberg Chiropractic any and all insurance benefits, settlement or judgment proceeds due to them, which are or shall become payable to me as a result of my injuries. I agree to see that all charges incurred with Garberg, Chiropractic are fully paid in the amount equal to their fee for treatment. I grant them an irrevocable lien on those benefits or proceeds for their fees. I am aware that I am solely responsible for paying Garberg Chiropractic for all treatment and services rendered at their office. I understand that at any time they may demand full or partial payment of those services.

I hereby consent to the performance of chiropractic treatment including but not limited to chiropractic adjustment, and diagnostic X-ray by Dr. Garberg,. I understand that no guarantee or assurance has been given about this treatment.

Patients signature:	**Date:**
If minor, parent's signature:	**Date:**

MEDICARE DISCLAIMER

To our Medicare patients; We accept assignment on all Medicare patients and chiropractic treatment is a covered service. Exams for chiropractic treatment are a non-covered service with Medicare. Routine maintenance visits are a non-covered service with Medicare. Medicare will not pay for products sold by a Chiropractor (i.e. Pillows, braces etc...) Charges not covered by Medicare or your supplemental insurance may become your responsibility. I have read and understand the above.

Patients signature	**Date:**