Evolve
INTEGRATIVE Chiropractic and Acupuncture
6200 E Canyon Rim Rd., Suite 109D, Anaheim Hills, CA 92807
tel 714.584.5190 · fax 714.386.5306

NEW PATIENT REGISTRATION

Patient's Name:_____ DOB:_____ Today's Date:_____
Address:_____ Age:_____ Gender: M / F
City: _____ State:_____ Zip:_____
Home Phone:(____)_____ Email:_____
Patient Employer:_____ Patient Occupation: _____
Name of Referring Physician / How you heard about us: _____
Name of Primary Physician:_____
Emergency Contact:_____ Relationship:_____ Phone: (____)_____

********INSURANCE INFORMATION********

Party responsible for payment?

☐ Insurance ☐ Self-Pay ☐ Auto-Accident/Slip-and-Fall ☐ Worker's Compensation Injury

In addition to your insurance card this information must be completed in order for us to courtesy bill your insurance company.

PRIMARY Insurance Co:_____ Insured Employer:_____
Name of Insured:_____ DOB: _____ Relationship: _____
Group #:_____ Policy #:_____ Insured's SSN: _____
SECONDARY Insurance Co:_____ Insured Employer:_____
Name of Insured:_____ DOB: _____ Relationship: _____
Group #:_____ Policy #:_____ Insured's SSN: _____

For Personal Injury Only
Do you have an attorney? What is your attorney's name? _____
What is your attorney's address?_____ Phone: (____)_____

VERIFICATION OF INSURANCE COVERAGE

Please initial

_____It is my responsibility to know the benefits, limitations and exclusion of my individual insurance plan.

Verification/Authorization of coverage is <u>not</u> a guarantee of payment and Evolve Integrative Health is not responsible if information provided is incorrect.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

Please initial

_____I am responsible for any unpaid balance, **regardless of any insurance coverage.** I assign all medical benefits to which I am entitled to be paid directly to Evolve Integrative Health. In the event payment is made directly to me, I agree to promptly remit payment to this office. If legal action becomes necessary to collect payment, I am responsible for all costs incurred, including collection agency and legal fees.

DEDUCTIBLES, CO-PAYS AND COINSURANCE

Please initial

_____**My co-pay is due at the time of service** unless prior financial arrangements have been made. We will bill your insurance for the balance of services provided as a courtesy.

CASH PATIENT

Please initial

_____**Payment in full is due at time of service** unless prior financial arrangements have been made.

CANCELLATION / RESCHEDULE POLICY

Please initial

_____ Patients who consistently miss their appointments or fail to cancel 24 hours in advance **may be charged a $40 penalty for missed appointments**. If your check is returned by the bank a $20 service charge will be added to your account.

I have read and fully understand the above information and agree to comply as outlined above.

_____

Patient Signature (if minor, parent's signature) Date