Patient Account # _____

APPLICATION FOR CARE - GEERS FAMILY CHIROPRACTIC

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist.

PERSONAL INFORMATION

Last Name_____ **First Name**_____ **Middle Initial** _____

Home Phone (____)_____-_____ **Work Phone** (____)_____-_____ **Cell phone** (_____)_____-_____ (Star the best number to reach you.)

Address _____**City**_____ **State**_____ **Zip**_____

Birthdate_____ **Marital Status:** S M W D **Email** _____ _____

Employer_____ **Occupation** _____

Will Insurance be Involved? Yes No **How did you hear about us?** _____

INSURANCE INFORMATION

Primary Insurance Co. _____ Group # _____ I.D. # _____

Policy Holders Name_____ Policy Holders Birthdate_____ Policy Holders SS # _____-_____-_____

Secondary Insurance Co. _____ Group # _____ I.D. # _____

SPOUSE or PARENT INFORMATION

Name of Spouse or Parent: _____**Birthdate** _____

Employer _____ Occupation _____

MAJOR SURGERIES OR CONDITIONS

_____

_____

_____

_____

CURRENT MEDICATIONS

_____

_____

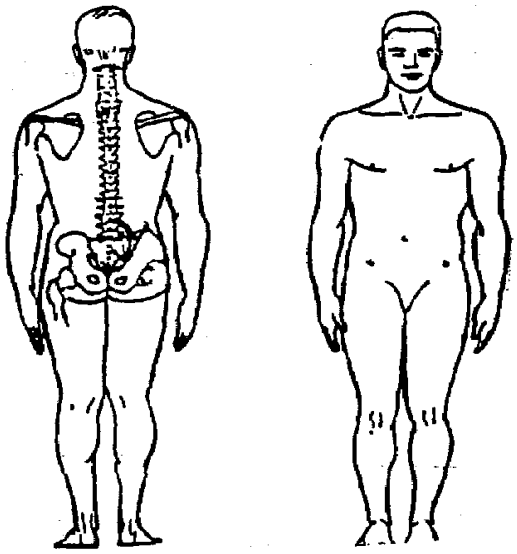
MAJOR COMPLAINTS

_____

_____

_____

_____



Please indicate on the figures where you have discomfort.

Have any other doctors recently treated you for this condition? _____

Have you done any treatments at home for this condition? _____ If yes, what? _____

Are you currently pregnant? _____ If yes, when are you due? _____

ACCIDENT INFORMATION

Is your condition due to an accident? YES NO *If yes, **Date of Accident** _____

If YES, please briefly describe: _____

Type of accident: (Circle One) Auto Work/On the job At home Other _____

Records Release: I authorize you to release any information including diagnosis and records of treatment to _____ Initial_____

AUTHORIZATION, ASSIGNMENT & RELEASE FORM

In consideration of your undertaking to care from me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges you incurred.

2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney out the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you, based in whole or in part upon the charges made for your services.

3. In the event any insurance company, obligated by contractual agreement to make payment to me or to you for the charges made for your services, refuses to make such payment upon demand by you, I herby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is (are) believed to be correctly set forth under pertinent date), and authorize you to prosecute and take action in my name as you see fit. I further authorize you to compromise, settle or otherwise receive and claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed directly from me. I understand that whatever amounts you do not collect from the insurance companies' proceeds, whether it is all or part of what is due, I personally owe and agree to pay to you.

4. In addition to the above, I herby waive the statute of limitations on collection and/or recovery in this State of Michigan.

5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.

6. This Authorization and Assignment will be in continual effort until revoked by both parties.

_____ _____

Date Patient/Insured Signature

TERMS OF ACCEPTANCE

When a patient seeks Chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and method that will be used to attain it. This will prevent any confusion or disappointment.

ADJUSTMENT

An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

HEALTH

A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

VERTEBRAL SUBLUXATION

A misalignment of one or more of the 24 vertebra in the spinal column which causes alternation of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to be at its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Our only practice objective is to eliminate nerve interference, with a specific adjustment to correct vertebral subluxations.

_____ _____

Signature Date