# Patient Registration

## Patient Information

Date _____ Preferred Language _____

Patient Name _____
First Name

_____
Middle Name Last Name

Social Security # _____

Address _____

City _____

State _____ Zip _____

Date of Birth _____ Age _____

Sex ☐ m ☐ f Race _____

☐ married ☐ widowed ☐ single ☐ minor

☐ separated ☐ divorced ☐ partnered ___ years

Email _____

Do we have permission to email you about your appointments? ☐ Y ☐ N

**How or who referred to our office?** _____

_____

## Phone Numbers

Home Phone ( ) _____

Cell Phone ( ) _____

Cell Carrier _____

Nearest Relative _____

Phone Number _____

## Medical Questions

Family Medical Doctor _____

When Doctors work together it benefits you. Do we have permission to contact your doctor about your care?

☐ Y ☐ N

**Women Only**: Are you pregnant or is there any possibility you man be pregnant? ☐ Y ☐ N ☐ ?

Do you smoke? ☐ Y ☐ N

# Desert Sun Chiropractic
## Financial Policy

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. Regardless of your coverage, we'll suggest the chiropractic care you need. We ask that you read and understand our policy as it applies to your situation.

**PATIENTS WITHOUT INSURANCE**
We request that 100% of the first visit be paid at the time of the service. On other visits, payment may be made at the end of the week if you sign a credit guarantee form. We are happy to accept your check, Mast Card, Visa, and American Express. We also accept Care Credit.

**GROUP OR INDIVIDUAL INSURANCE**
Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do. The amount varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles or co-pays.

**PERSONAL INJURY OR AUTOMOBILE ACCIDENTS**
Please present your auto insurance card, your health insurance card and tell us if you have retained an attorney. There are four options available to the PI patient:

1. Pay cash for your care and we will submit reports and necessary.
2. We will bill (accept assignment) from the Med Pay/Personal Injury Protection (PIP) portion of your auto insurance.
3. We will accept a Letter of Protection from an APPROVED attorney and await payment at the time of settlement as long as you remain an active patient.
4. We will bill your standard health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

**MEDICARE**
We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deducible has been met. You are required to pay the deductible and the remaining 20%. All other services we provide are NON-COVERED. These services include, but are not limited to: x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

**SECONDARY INSURANCE**
Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

**MANAGED CARE PLANS**
We are preferred providers for most insurance companies. Some plans require you to pay a co-pay at the time of service. Other plans may have a deducible amount to be met first. After the deductible is satisfied, you and your insurance company will share the percentage of the cost that varies from plan to plan. A referral from your primary care physician may also be necessary. Out of network benefits are usually available if a referral is not obtained.

**FLEX PLANS/MEDICAL SAVINGS ACCOUNTS**
Please inform us if you have a medical savings account, sometimes known as a 'flex plan.' We will be happy to provide you with a statement of your charges for reimbursement.

**CREDIT CARD GUARANTEE/ELECTRONIC DEBIT**
ALL patients with ALL types of cases (patients without insurance, group or individual insurance, personal injury and medicare) are required to have a Credit Card Guarantee and/or and Authroization for Electronic Debit on file.

**FINANCING OPTIONS**
Our clinic works hard to give you affordable care that has been recommended to you. We offer Care Credit for a financing option. Ask for details.

**INSURANCE FORMS/PAYMENT**
If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file up to date as possible. Occasionally, either by mistake, or due to a provision in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill for services performed in our office.

I have read and understand the payment policy of Desert Sun Chiropractic. I understand that my insurance is an arrangement between me and my insurance company, and NOT between Desert Sun Chiropractic and my insurance company. I request that Desert Sun Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed the doctors at Desert Sun Chiropractic that fees will be due and payable immediately.

_____ _____
Patient's signature (or guardian if patient is a minor) Date

_____
Witness

**SPECIAL PAYMENT INSTRUCTIONS**

Patients Name _____

We have verified your benefits and while your insurance company DID NOT guarantee payment, they stated that you have a $_____ deductible, $_____ of which has been met. Additionally, your insurance will pay _____% of covered charges, leaving _____% of each visit due by you.

We have verified your benefits and while your insurance company did not guarantee payment, they stated that you have a $_____ deductible, $_____ of which has been met. Additionally, your insurance will pay _____% of covered charges, leaving $_____ co-pay of each visit due by you.