FOSS SPINE & WELLNESS

New Patient Intake

Date: _____ Name: _____ SSN: _____

How did you hear about us? □ Family/Friend _____ □ Facebook □ Google □ Sponsorship □ Other

Date of Birth:_____ Age: _____ Gender M or F Email: _____

Address: _____ City: _____ State: _____

Zip: _____ Cell Phone: _____ Home Phone: _____

Occupation: _____ Employer: _____

Work Phone: _____ Spouse Name: _____

Spouse Occupation: _____ Marital Status: _____ # Children: ____

Emergency Contact: _____ Phone #: _____Relation: _____

Payment Information

Health Insurance Company (if applicable, please present cards): _____

Do you have MEDICARE? □ Yes □ No Medicare Supplemental Company: _____

If you have insurance, do you want us to bill them? □ Yes □ No

Payment Policies Agreement

I understand that I am responsible for any uncovered charges that the insurance doesn't pay for any reason. If I ask that insurance be billed, I understand and consider reasonable that the office will use the fee schedule and coding for chiropractors as generally determined by the State of Minnesota workers compensation rate; and I hereby assign my insurance company/Medicare or their intermediaries to pay Foss Spine & Wellness health care benefits directly at the business address, to bill insurance for each medical service performed, and assign Dr. Jace to release any administrative or medical information necessary to process insurance claims. I understand there is a $30 charge for returned checks.

Privacy Disclosure (Updated 1/1/2017): This office conforms to the current HIPAA guidelines and policies for health information. A privacy policy is available at the front desk and may be requested if desired. I hereby authorize that my medical records may be forwarded to my other healthcare providers in the best interest of my healthcare or insurance payors in order to process claims information. I understand that Dr. Jace provides regular care in an open, multi-patient treatment area format and that if I have specifically confidential information to share, I will request and be provided private room consultation. I understand that omission of information on this health history, my compliance with care, and providing Dr. Jace and with accurate health condition updates will directly affect the ability of providers at Foss Spine & Wellness to come to proper diagnoses and provide safe and standard care and I agree to hold harmless Dr. Jace for any act of information omission on my part.

I hereby understand and agree to the privacy and payment policies and that the fee schedules are reasonable. I consent to chiropractic diagnostic and treatment procedures to be performed by Dr. Jace M. Foss, D.C.

Patient Signature (or guardian) _____ Date: _____