

Copper Canyon Chiropractic

James Skabo, D.C.

NEW PT. OR UPDATE

PATIENT REGISTRATION FORM

**** PLEASE FILL OUT COMPLETELY AND PRINT CLEARLY ****

TODAY'S DATE _____

PATIENTS NAME _____ DATE OF BIRTH _____ AGE _____ SEX _____

PT'S SOCIAL SECURITY # _____ Marital Status: Married / Divorced/ Widowed/ Single

LOCAL ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SUMMER ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE # (_____) _____ E-MAIL _____

EMPLOYER: _____ WK PHONE # (_____) _____

PRIMARY CARE PHYSICIAN NAME AND NUMBER _____

EMERGENCY CONTACT & PHONE #: _____

PRIMARY INS. COMPANY: _____ SECONDARY INS. COMPANY _____

POLICY HOLDER'S NAME _____ SSN# _____ D.O.B. _____

RELATIONSHIP TO PATIENT _____ EMPLOYER _____

WHAT IS YOUR YEARLY DEDUCTIBLE? _____ CO-PAY: \$ _____

PLEASE ALLOW OUR STAFF TO PHOTO COPY ALL INSURANCE CARDS-FRONT & BACK

DO YOU AUTHORIZE THIS OFFICE TO DISCUSS YOUR CARE OR TREATMENT WITH ANY PARTIES BESIDE YOURSELF? YES ___ NO ___ IF SO WITH WHOM: _____

RELEASE and ASSIGNMENT

I, the undersigned have insurance coverage with _____ and assign directly to **Dr James Skabo dba / Copper Canyon Chiropractic** all medical benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by said insurance, unless assignee has executed an agreement with my insurance provider or plan. I understand that if such agreement has been executed, I am responsible to pay any deductible and/or co-payment and non-covered services under the terms of my insurance. I understand that any payments, which are due, starting 30 days after insurance coverage has been completed, will be charged a \$3.00 monthly late service charge: (or) at a rate of 1.5% interest per month on unpaid balance, whichever is larger. I understand that I am financially liable in the event of non-payment; I agree to pay the collection agency's cost and/or court cost and reasonable attorney fees.

Signature of Insured / Guardian

Date

I request that payment of authorized Medicare benefits to be made directly to **Dr. James Skabo dba / Copper Canyon Chiropractic** On my behalf for any service furnished by that physician. I authorize any holder of medical information about me to release to CMS and its agents needed to determine these benefits payable for related services, I understand my signature request that be made and authorize release of medical information necessary to pay claim. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as full charge, and the patient is responsible for deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature

Date