

Sheppard Chiropractic, Inc.
1238 Ohio Pike Amelia, Ohio 45102 (513) 753-5437

REGISTRATION

Home Ph _____ Work Ph _____ Cell Ph _____ Pls Circle Best # to reach you
 Name _____ Best time to call: _____ am/pm
 Street Address _____
 City _____ State _____ Zip _____
 Social Security Number _____ Driver's License # _____
 Sex M F Age _____ Birth date _____ Single Married Widowed Separated Divorced
 Email Address _____ Number of Children _____

How and where did you learn about this clinic?

Condition / Illness Related To: Illness _____ Employment _____ Automobile _____ Other _____

HIPAA PRIVACY STATEMENT	By subscribing my name and signature below, I acknowledge that I have received a copy of the HIPAA guidelines and am in agreement to, and understanding with, its terms and conditions. Signature: _____ Date: _____
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AUTHORIZATION FOR CARE OF A MINOR	I hereby authorize Sheppard Chiropractic, Inc. and whomever they may designate as their clinicians to administer care as they so deem necessary to my son/ daughter / ward. Signaure of Parent or Guardian: _____ Date: _____
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EMPLOYER	Company Name _____ Occupation _____ Address _____ Phone _____ Full-time _____ Part-time _____ City _____ State _____ Zip _____
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SPOUSE (PARENT)	Name _____ Birthdate _____ Social Security Number _____ Employer Name _____ Occupation _____ Address _____ Phone _____ City _____ State _____ Zip _____
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MEDICAL AND LEGAL INFORMATION	Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury <u>someone else might be legally responsible for?</u> Yes No Your Initials _____ If you answered yes, please fill out the accident specific form, available at the front desk. Pregnant Yes No Pacemaker Yes No Family Physician _____ Person to contact in an emergency (Name & Phone #) _____ Attorney _____ Telephone: _____ Address: _____
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PATIENT AGREEMENT	<p>LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS</p> <p>In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Sheppard Chiropractic all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.</p> <p>I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.</p> <p>Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.</p> <p style="text-align: center;">_____ Signature of Insured / Guardian</p> <p style="text-align: center;">_____ Date</p>
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PLEASE SEE REVERSE