ARNE WELLNESS CENTER, P.C.

PATIENT INFORMATION (Please Print) **Date**_____

Name_____ **Marital Status:** **Single** **Divorced**
Home Phone _____ **Married** **Widowed**
Cell Phone _____ **Sex:** **Male** **Female**
E-Mail_____
Address_____
City_____**State**___**Zip**_____ **Age:**_____**Birthdate:**_____

Occupation_____

SPOUSE/PARENT INFORMATION
Name_____
Phone _____
Birthdate _____

Primary Care Physician
Doctor's Name_____
Address_____
City_____**State**____**Zip**_____

(This section for Chiropractic Patients Only)
PRIMARY INSURANCE: Insurance Company Name _____
Policy Holder Name: _____ **DOB:** _____
(please provide copy of your ID to front desk)

Consents & Acknowledgements:

All Patients Sign Chiro Patients Natural Medicine

RECORDS RELEASE: I hereby authorize the release of any information, including medical and billing information by ARNE CHIROPRACTIC AND WELLNESS CENTER, P.C. to my referring doctor/ primary care physician, insurance company, the responsible party named above, and immediate family on behalf of myself and/or dependents.

Date: ____/____/____ **Signed:** _____

FINANCIAL STATEMENT: I understand that any NON-COVERED SERVICES/SUPPLIES will be my responsibility. I agree to pay any collection costs, including but not limited to, filing and attorney's fees, if necessary.. **I WILL BE CHARGED FOR APPOINTMENTS CANCELLED OR BROKEN WITHOUT 24 HOURS ADVANCE NOTICE.**

Date: ____/____/____ Signed: _____

ASSIGNMENT OF BENEFITS: I hereby authorize payment of Chiropractic Benefits to ARNE CHIROPRACTIC AND WELLNESS CENTER, P.C. for services rendered to me and /or dependents.

Date: ____/____/____ Signed: _____

INFORMED CONSENT FOR CHIROPRACTIC: I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me (or patient named below, for whom I am legally responsible) by the licensed doctors of chiropractic at Arne Chiropractic and Wellness Center. I understand and am informed that there are some risks to treatment, including but not limited to fractures, disc injuries, stroke, dislocations and sprains. I understand these risks are considered "rare" and do not expect the doctor to be able to anticipate and explain all risks and complications. By signing below I intend for this consent form to cover the entire course of treatment for my present and future conditions for which I seek treatment and release my provider from any liability.

Date: ____/____/____ Signed: _____

INFORMED CONSENT FOR SUPPLEMENTATION: I acknowledge and agree that prescribed supplements and/or care may be assigned based on clinical evaluation, functional testing, and/or electrodermal screening. I understand that official diagnostic testing may not be done prior to supplement implementation. I hereby release the provider and clinic from any liability rising from the use of treatments and supplements recommended without diagnostic testing.

Date: ____/____/____ Signed: _____

TREATMENT OF MINOR CHILD: I hereby authorize Dr. Robert Arne to provide evaluation, management and/or chiropractic treatment for my child _____. I also authorize whomever Dr. Arne may designate as assistants to administer therapy.

Date: ____/____/____ Signed: _____

MEDICARE AUTHORIZATION: _____. I request that payment of authorized Medicare benefits be made to me or on my behalf to ARNE CHIROPRACTIC AND WELLNESS CENTER, P.C. for any services furnished me by that physician/clinic/supervisor.

Date: ____/____/____ Signed: _____