



2177 Troop Drive  
Sartell, MN 56377  
(320)257-8266

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Legal Information**

Legal Name \_\_\_\_\_ Nick Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Home Phone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Work Phone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Ext: \_\_\_\_  
Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age today: \_\_\_\_ Gender: Male \_\_\_\_ Female \_\_\_\_ Email \_\_\_\_\_  
Permanent Address if different from above (ex: college students) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**Personal Information**

Your physician's name: \_\_\_\_\_ Phone #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Your chiropractor's name: \_\_\_\_\_ Phone #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Have you ever been in an automobile accident? Yes \_\_\_\_ No \_\_\_\_ If so, when? \_\_\_\_\_

**Marital Status**

\_\_\_\_ single \_\_\_\_ married \_\_\_\_ legally separated \_\_\_\_ divorced \_\_\_\_ widowed \_\_\_\_ other

**Family**

Spouse/Partner's Name \_\_\_\_\_ Children/Ages \_\_\_\_\_

**Referred By**

Doctor \_\_\_\_\_, MD/DC at \_\_\_\_\_ Clinic  
Yellow Pages, Friend: \_\_\_\_\_, Insurance Book/Other \_\_\_\_\_

**Employment**

\_\_\_\_ Full Time \_\_\_\_ Part Time \_\_\_\_ Retired \_\_\_\_ Unemployed \_\_\_\_ Specify other  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

**Insurance Information**

Primary Insurance Company \_\_\_\_\_ Co-pay \$ \_\_\_\_\_  
Policy Holder's Name \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  
Relationship to Policy Holder \_\_\_\_\_ Policy Holder's Employer \_\_\_\_\_  
Secondary Insurance Company \_\_\_\_\_  
Secondary Insurance Policy Holder's Name \_\_\_\_\_  
Secondary Insurance Policy Holder's Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Worker's Compensation Claim filed for this injury? Yes \_\_\_\_ No \_\_\_\_  
Auto Accident Claim filed for this injury? Yes \_\_\_\_ No \_\_\_\_  
Date of Work Injury or Auto Accident \_\_\_\_/\_\_\_\_/\_\_\_\_

**Please present your insurance card to the reception desk so that we can make a photo copy for your file. (Unless you are paying cash)  
Thank You!**

## **Office Policies Regarding: Personal Health Insurance & Private Payment**

1. I authorize Synergy Chiropractic and Wellness Clinic to release any information in the event my insurance company/attorney requests records or information related to my treatment at your office.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

2. We are providers for several insurance programs and managed care organizations. For your convenience we will verify your insurance benefits and submit claims as a courtesy to you. However, your insurance is a contract between you and your insurance company, NOT between Synergy Chiropractic and Wellness Clinic and your insurance company. **You are fully responsible for all charges due to services rendered. If payment is denied for any reason by your insurance company, you are then responsible for full payment of those services rendered.**
3. Supplies and services such as, but not limited to nutritional supplements, ice/hot packs, pillows, orthotics, and spa services are not covered by your insurance policy. Therefore, you are required to pay for them at the time of service. After 15 days of purchase, unused or unopened items may be returned for credit only. No returns or credit after 30 days from purchase. **Any items that have been opened or used may not be returned. Pillows, homeopathic remedies, and custom orthotics may NOT be returned under any circumstances.**
4. All charges must be paid at the time of services. This includes co-pays and deductibles.
5. Any insurance payments that have been paid directly to you by your insurance company must be received by Synergy Chiropractic and Wellness Clinic no later than one week from receipt and endorsed to this clinic.
6. 1.5% interest will be charged on all balances that are 60 days past due from the time the first statement is sent to you. If you experience financial difficulties, please call us. We will do our best to work out a payment plan. If balances are not paid within 90 days for the time of the first statement, and arrangements for payment have not been made, your account will be referred for legal action.

I have read, understand, and accept the payment policy at Synergy Chiropractic and Wellness Clinic.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **Cancellation Policy**

We require a 24-hour notice if you cannot keep your appointment at Synergy Chiropractic and Wellness Clinic for any service. If the appointment is not cancelled, or if you do not come in for the appointment, we reserve the right to charge up to the full amount for the service (with the exception of chiropractic care under your health insurance). Subsequent appointments will require a credit card to hold your appointment time.

We appreciate having you as a patient at Synergy Chiropractic and Wellness Clinic. This policy will help us keep appointment times available for you and keep our fees at a reasonable level.

**I have read and understand the above.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the reception desk before signing this consent.

1. The patient understands and agrees to allow Synergy Chiropractic and Wellness Clinic to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_