WATERTOWN CHIROPRACTIC P.C.

2320 9th Avenue SE Watertown SD 57201• (P) 605-882-2304 • (F) 605-882-0626

## CONFIDENTIAL PATIENT INFORMATION

**Patient Information** **Today's Date _____**

Name (Last,MI, First)_____ Date of Birth _____

Street Address _____

City _____ State _____ Zip _____

Home Phone (___)____-_____ Cell Phone (___)____-_____

E-mail _____ Social Security# _____-____-_____

Marital Status: ☐ S ☐ M ☐ W ☐ D

Race _____ Gender ____M ____F ____Left-Handed ____Right-Handed

Smoking status __Never __Former __Current __How much? _____

Referred By _____ Primary MD _____

Employer/School _____ Occupation _____

Employer/School Address _____

Emergency Contact/Relation _____Emergency Contact Phone Number (___) _____-_____

**Reason For Today's Visit**

List present complaints and injuries _____

_____

How long have you had this condition? _____ Does it bother you occasionally/frequently/constantly?

Who else have you seen for this condition? _____

What did they recommend? _____

**HIPAA**: This notice describes how chiropractic and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Here are some examples of how we might have to use or disclose your care provider. Our insurance and billing department may have to disclose examination and treatment records to another party; such as, an insurance carrier, an HMO, a PPO, your employer, or your lawyer. The medical staff may have to use your information to call you regarding your appointment. Your information may be used for quality purposes or other administrative purposes. You have the right to refuse to give us authorization to contact you in order to provide appointment reminders or other information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care. WE have and always will respect your privacy! Other than the uses or disclosures we described above, we will not sell or provide any of your health information to any outside marketing organization. We are required, by law, to maintain the privacy of your health information and to provide you with this notice of our legal duties and privacy practices.

X **INTIALS:_____**

**Treatment of a MINOR:** I grant Watertown Chiropractic P.C. and staff permission to provide chiropractic treatment to my child. I further give permission to the clinic and staff to contact my child's primary care physician regarding past medical history.

X Signature of Parent of Guardian:_____

**Treatment:** I hereby authorize the doctor to treat my condition as he deems appropriate through the use of chiropractic healthcare, and I give authority for these procedures to be performed.

X Signature of Patient:_____ Date:_____

## 2025 Insurance Information and Assignment Authorization

**Patient's Name _____ Date _____**

**Patient's Social Security # ___/___/___ Insurance Company _____**

**Insurance Policy # _____ Group # _____**

**Assignment Authorization and Agreement**

I agree to provide the office with any **information, initial or follow up referral forms** prior to seeing the Doctor that are necessary for treatment or payment and

1. I hereby assign to this office my rights to receive payments from negligent parties or from insurance companies. Payments should be payable and mailed to:

   Watertown Chiropractic P.C.
   2320 9th Avenue SE
   Watertown SD, 57201

2. I authorize the office to release any information to any insurance company, adjuster or attorney that will assist in the payment of a claim.
3. **I fully understand and agree that insurance policies are an arrangement between an insurance carrier and myself. I will be responsible for any expenses not paid by insurance.**
4. A photocopy of this form shall be as valid as the original.

_____ _____

Patient's Signature Date

# Payment Policy

To pay your balance once your insurance company has processed your visit, a current credit card needs to be on file with authorization of payment. Once the insurance claim is processed your credit card will be charged the balance and an itemized receipt will be mailed to you.

## Payment Authorization

I hereby authorize Watertown Chiropractic P.C. to automatically charge my credit card for:

1 The allowable balance due after my insurance payments are made.
2 For insurance payments sent directly to me.
3 For my co-payment when due.
4 For non-covered services.
5 Missed Appointment fee. ($20)

A copy of the itemized statement and credit card receipt will be provided for your records.

Would you like a copy of your receipts?

□Yes □No

Name:_____ Date:_____

Signature:_____ Zip Code: _____

MC/Visa Card#_____ Expiration Date:_____

AmEx Card#_____ Expiration Date:_____