NEW PATIENT INFORMATION QUESTIONNAIRE

Date: ___/___/___ **REFERRED BY: _____**

PATIENT NAME: _____ **Soc. Sec. Number: _____-_____-_____**

Birth Date: ___/___/___ Age: _____ Sex: ( ) M ( ) F ( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed

Home Address: _____ City: _____ State: _____ Zip: _____

Employed By: _____ Occupation: _____ Student: ( ) Full time ( ) Part time

Business Address: _____ City: _____ State: _____ Zip: _____

Home/Cell Phone: (_____) _____-_____ **Business Phone: (_____) _____-_____ Ext:_____**

Name of Spouse: _____

Spouse Employed By: _____

INSURANCE INFORMATION:

( ) Health Insurance **Insurance Company/HMO: _____** **Policy #: _____**
( ) Auto Accident **Auto Insurance Company: _____** **Claim #: _____**
( ) Medicare **Medicare #: _____**
( ) Private Pay

AUTHORIZATION TO TREAT: I, the undersigned, a patient in this clinic, hereby authorized **Grant F Stoddard, DC, DAAPM** President of Allied Physicians Clinic, and whomever he designates, to administer such chiropractic and/or therapeutic treatment as they consider clinically necessary on the basis of findings during the set course of treatment.

NO PROMISE OF CURE AND POSSIBLE RISKS IF ANY: I hereby certify that I have read and fully understand the above authorization for chiropractic, the reasons why the above treatment is indicated, its advantages and possible complications, if any, as well as possible alternative treatment which were explained by the doctors and/or their staff. I also certify that no guarantee or assurance has been made as to the results which I may expect to obtain. Medical Physicians, Chiropractors, Osteopaths and Physiotherapists using manual therapy are required to advise patients with neck problems that there have been rare incidents of injury to the Vertebral Artery during the course of treatment. These have caused strokes or stroke-like occurrences, which are usually of a temporary nature. The chances of this happening are approximately 1 in 2 million treatments. Appropriate tests will be performed on you to minimize the risk.

AUTHORIZATION is hereby granted to **Allied Physicians Clinic,** to release any information acquired in the course of my examination and treatment to any insurance company, attorney or adjuster. **I AUTHORIZE and ASSIGN DIRECT PAYMENT to Allied Physicians Clinic,** of any sum I now or hereafter owe this office, by my attorney out of the proceeds of any settlement of my case, and/or by any insurance company obligated to reimburse me for the charges for these services. **I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and the insured. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment, and I agree to pay all billings on a timely basis.** I understand that a finance charge of 1.5% per month will be charged on accounts over 30 days past due, until the bill has been paid in full.

I understand that in personal injury cases, providing that no other insurance is involved, payment may be deferred until settlement, with the total due in full at settlement.

I further understand that if I suspend or terminate my treatment in this office, any fees for professional services rendered to me will be immediately due and payable. **I also agree to pay all collection fees and any and all reasonable legal fees as well as court costs incurred in the collection of this account.**

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and health care rendered by physician/facility. I waive the Statute of Limitations regarding my doctor's right to recover.

PATIENT SIGNATURE: X _____ **DATE: ____/_____/_____**

A PHOTOCOPY OF THIS INSTRUMENT SHALL SERVE AS ORIGINAL.

Allied Physicians Clinic, 2704 Southern Blvd. Ste. #3 SE, Rio Rancho, NM 87124
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