ALL STAR HEALTH
SPINE & SPORTS CARE

About You

First Name: _____ MI: _____ Last Name: _____
[ ]Male [ ]Female SS #: _____ Birthdate: ____/____/____ Age: _____
Ethnic Origin/Race: _____ Preferred Language: _____ Email: _____
Address: _____ Apt: _____
City: _____ State: _____ Zip: _____
Home #: _____ Cell #: _____ Wk #: _____ Ext: _____
Occupation: _____ Employer: _____
Marital Status: S M D W # of children: _____ Spouse's Name: _____
(if minor) Parent or Guardian: _____
In case of emergency, whom should we contact? Name: _____ Phone #: _____
Name of your family doctor: _____ Phone #: _____
Next appointment with your doctor: ____/____/____ (if applicable)
May we contact your family doctor if needed? [ ] Yes [ ] No

Insurance Information

We will make a copy of your insurance card(s). However, please complete the following information.

Are you the policy holder? **[ ]Yes [ ]No** If **YES,** skip this section. If **NO**, please complete this section.
Insurance Name: _____ Insurance Phone #: _____
Policy Holder's Name: _____ Policy ID#: _____
Birthdate: ____/____/____ [ ]Male [ ]Female Policyholder's SS #: _____
Address: _____
Employer: _____

Do you have secondary insurance coverage: [ ]Yes [ ]No If **YES**, please complete this section.
Insurance Name: _____ Insurance Phone #: _____
Policy Holder's Name: _____ Policy ID#: _____
Birthdate: ____/____/____ [ ]Male [ ]Female Policyholder's SS #: _____
Address: _____
Employer: _____

We reserve the right to collect a $50 fee for cancellations with less than 24 hour notice. Initial: _____

Assignment & Release

* I understand & agree that health & accident insurance policies are an agreement between an insurance carrier & myself. Furthermore, I understand that this office will prepare any necessary reports & forms to assist me in making collection from the carrier & that any amount authorized to be paid directly to this doctor's office will be credited to my account upon receipt.
* As a courtesy to you, we will verify your health care benefits for this office. You will then be responsible for any co pays and deductibles.
* Your health insurance is a contract between you & the insurance carrier. In the "rare" event that your insurance company is in "bad faith" & after our office has made every attempt to have all claims paid, we will have you, the patient, be responsible for contacting your insurance carrier to have the claims paid.
* If your insurance company has not paid within 120 days of billing, you will be responsible to pay the balance due.
* If Collection efforts become necessary to enforce payment terms, the patient agrees to pay all collection costs, attorney's fees, & other costs associated with collecting this balance.
* I hereby authorize & release the doctor & his/her assistants, to administer treatment, physical examination, x-rays studies, chiropractic care, physical therapy or any clinic services that he/she deems necessary in my case; I furthermore authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to patient or a family member or employer of the patient for all or part of the clinic's charge, including & not limited to hospital or medical services companies, worker's compensation carriers, welfare funds, or the patient's employer.

Signature: _____ **Date:** ____/____/____

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