

Life Quest Chiropractic & Rehabilitation

510 22nd Avenue East, Suite 701 Alexandria, MN 56308 Phone: 320-763-9711 Fax: 320-762-1278

Registration

Name: _____ M / F
 First Middle Last

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Birthdate: _____

SS#: _____ - _____ - _____ Email: _____

Medical Doctor: _____ Clinic: _____ OK to contact him/her? Y / N

Occupation: _____ Employer: _____ Phone: _____

Marital Status: M S D W Children (name and age): _____

Spouse: _____ Spouse's Employer: _____

How did you hear about us? Yellow Pages Newspaper Internet Screening Radio TV Employer

I was referred by: _____

Please present your Photo ID and Insurance Card to the Front Desk. Thank you.

Assignment and Release

- 1) I hereby consent to treatment by the doctor of Life Quest Chiropractic and Rehabilitation. if applicable, I hereby consent to have treatment for my minor child(ren).
- 2) I hereby give consent to publish x-rays, testimonial or case study as a result of treatment.
- 3) I, the undersigned, certify that I (or my dependent) have personal health insurance coverage with _____ and assign directly to Life Quest all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am personally responsible for all charges accrued whether or not paid, or covered, by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient Health Information Consent Form

I, the patient, understand and agree to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. Life Quest wants you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of you Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to have access to your medical records, please inform the assistant at the Front Desk.

Signature

Date

Signature of Parent or Guardian of under 18

Date

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