



6850 N. Rochester Rd. Rochester Hills, MI 48306
PHONE: (248)-923-1395 FAX: (248)-721-4083

Please allow our staff to make a copy your driver's license and insurance details. All information you supply is confidential. We comply with all federal privacy standards. Please print clearly.

Today's Date (MM/DD/YYYY) _____ Whom may we thank for referring you? _____

PERSONAL

Last Name _____ First _____ Middle(or Initial) _____

Street Address _____

City _____ State/Province _____ ZIP/Postal Code _____

Home Phone _____ Cell _____ Email Address _____

Gender Male Female Birth Date (MM/DD/YYYY) _____ Social Security Number _____

Marital Status Single Married Divorced Widowed Separated Spouse's Name _____

Other Family Members _____

Occupation _____

Employer _____ Phone _____

Preferred method of contact Home Phone Cell Phone Work Phone Email

Primary Care Physician _____ Phone _____

Emergency Contact _____ Phone Number _____

INSURANCE

Insurance Carrier _____ Policy Number _____ Carried by Self Spouse Parent

Insured's Last Name _____ First _____ Middle Initial) _____

Insured's Birth Date (MM/DD/YYYY) _____ Social Security Number _____

Insured's Employer _____ Phone _____

Street Address _____

City _____ State/Province _____ ZIP/Postal Code _____

PREVIOUS CHIROPRACTIC CARE

Have you seen a Chiropractic Physician before? ___ Yes ___ No

Who? _____ When? _____

Reason for Visit at that time: _____

How did you respond? _____

ACKNOWLEDGEMENTS

In order to set clear expectations, improve communication and help you attain the best results, please read each statement and **initial your agreement**.

_____ I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered at Health Loft Chiropractic is based on evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art form from medicine and does not proclaim to cure any named disease or entity.

_____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

_____ **FEMALES ONLY** I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY) _____

_____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information, as an extension of my care in this office.

_____ I acknowledge that any insurance I may have is an agreement between the carrier and myself and that I am responsible for the payment of any covered or non-covered services that I receive.

_____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

If the patient is a minor child, print child's full name: _____

Signature

Date

Insurance Policy and Fee Schedules

- Consultation includes practice member history. This is a complimentary service.
- Examination (new patient and established patient) includes one or more of the following: range of motion, motion and/or static palpation, muscle testing, dermatome testing, and leg check.
- Chiropractic Adjustment, this is the actual realignment of the vertebra, a manual or specific instrument spinal adjustment will be delivered to help re-align the vertebra.
- X-rays may be taken with specific views of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to help indicate progress after a period of care.

Release of Authorization/Assignment of Benefits

I authorize the release of any information necessary to process my insurance claims. I authorize and request payment of insurance benefits directly to Dr. Marie Palazzolo-Meyer, DC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for the service when rendered unless other arrangements have been made in advance. I understand that I am Financially responsible for any charges not covered by this assignment.

Signature

Date