Ins:ght OSTEOPATHIC MEDICINE

Personal &Work Information

Date:_____ Patient Name:_____ Age:_____

Birth Date:____/____/____ Social Security#: ____-____-____ ☐M ☐F Home Phone:_____

Address: _____ Mobile Phone: _____

City: _____ State:_____ Zip: _____

Occupation: _____ Employer: _____Work Phone: _____

Email:_____

Emergency Contact:_____ Relationship: _____ Phone(s): _____

How did you learn about our practice? _____

Primary Care Physician: _____ PCP Phone: _____

Financial & Insurance Information

Please choose one: ☐I will pay my balance in full at time of service. ☐Please bill my insurance; I will present you with my insurance card

Insurance company: _____ ID#_____ Group#_____

Secondary Insurance:_____ ID#_____ Group#_____

Complete the following information about the *Insurer* if other then self: Name:_____ ☐M ☐F

Birth Date: ____/____/____ Address, City, St, Zip:_____

Relationship to Insurer: ☐Self ☐Spouse ☐Child ☐Partner

Motor Vehicle Accident or Workers Compensation:

Insurance Company:_____ Claim Number:_____ Date injured:_____

Adjuster's Name:_____ Adjuster's Phone:_____

Records Release & Assignment of Insurance Benefits

The undersigned hereby authorizes the **Release of Information** relating to claims for benefits submitted. I agree and acknowledge that I authorize my physician /practitioner to submit claims for benefits, for services rendered, without obtaining my signature on each claim.

I (patient)_____ hereby authorize (Insurance Co.) _____
to pay and hereby assign directly to Insight Osteopathic Medicine, LLC all owed benefits. I understand I am financially responsible for all charges incurred.

_____ _____ _____
Patient Signature or Guardian if patient is under 18 years of age | Relationship to patient | Date

Notice of Privacy Practices (HIPPA)

My signature below acknowledges that I have had the opportunity to review the privacy practices regarding my protected health information.

_____ _____ _____
Patient Signature or Guardian if patient is under 18 years of age | Relationship to patient | Date

Consent Form & Agreement

Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to soreness, inflammation, soft tissue injury, dizziness, burns and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side effects and complications is available upon request. It is also our policy to inform you of the procedure being performed and the risks and alternative treatments available. If your physician/practitioner does not explain to your satisfaction, please ask for more information. I have read and understand the above statements regarding treatment side effects and I also understand that there is no guarantee for a specific cure or result.

_____ _____ _____
Patient Signature or Guardian if patient is under 18 years of age | Relationship to patient | Date