ARNE WELLNESS CENTER, P.C.

PATIENT INFORMATION (Please Print) **Date**_____

Name_____ **Marital Status:** **Single** **Divorced**
Home Phone _____ **Married** **Widowed**
Cell Phone _____ **Sex:** **Male** **Female**
E-Mail_____
Address_____
City_____**State**___**Zip**_____ **Age:**_____**Birthdate:**_____

Occupation_____
Employer_____
Address_____
City_____**State**____**Zip**_____
Work Phone_____

SPOUSE/PARENT INFORMATION
Name_____
Employer_____
Occupation_____
Work Phone_____
Birthdate_____

Primary Care Physician
Doctor's Name_____
Address_____
City_____**State**____**Zip**_____

PRIMARY INSURANCE
Type: **Group** **Private**
Medicare **Auto Acc.**
Med Asst

Ins. Co. Name_____
Address_____
City_____**State**____**Zip**_____
Group#_____**Contract#**_____
Medicare #_____
Subscriber Name_____
Relationship: **Self** **Spouse** **Depend.**

SECONDARY INSURANCE INFORMATION
Ins. Co. Name_____
Address_____
City_____**State**____**Zip**_____
Group#_____**Contract#**_____

Was Condition Caused By:
A. An injury during employment?
Yes **No**
If yes, please fill out form "A"
B. An auto accident?
Yes **No**
If yes, please fill out form "B"
C. Other injury?
Yes **No**

REFERRED BY:
Individual_____
Yellow Pages____**Local**___**Denver**
Employer_____
Physician_____
Insurance_____
Building/Sign_____
Advertisement_____
Other_____

ARNE WELLNESS CENTER, P.C.

PRIVACY POLICY: *I acknowledge that I have received Arne Chiropractic and Wellness Center's privacy policy.*

Date: ___/___/___ **Sigmed:** _____

RECORDS RELEASE: *I hereby authorize the release of any information, including medical and billing information by ARNE CHIROPRACTIC AND WELLNESS CENTER, P.C. to my referring doctor/primary care physician, insurance company, the responsible party named above, and immediate family on behalf of myself and/or dependents.*

Date: ___/___/___ **Signed:** _____

ASSIGNMENT OF BENEFITS: *I hereby authorize payment of Chiropractic Benefits to ARNE CHIROPRACTIC AND WELLNESS CENTER, P.C. for services rendered to me and /or dependents.*

Date: ___/___/___ **Signed:** _____

FINANCIAL STATEMENT: *I understand that any NON-COVERED SERVICES/SUPPLIES will be my responsibility. I agree to pay any collection costs, including but not limited to, filing and attorney's fees, if necessary. I agree to pay a one and one quarter percent per month (fifteen percent annual) finance charge for balances over sixty days.* I WILL BE CHARGED FOR APPOINTMENTS CANCELLED OR BROKEN WITHOUT 24 HOURS ADVANCE NOTICE.

Date: ___/___/___ **Signed:** _____

TREATMENT OF MINOR CHILD: *I hereby authorize Dr. Robert Arne to provide evaluation, management and/or chiropractic treatment for my child* _____. *I also authorize whomever Dr. Arne may designate as assistants to administer therapy.*

Date: ___/___/___ **Signed:** _____

MEDICARE AUTHORIZATION: _____. *I request that payment of authorized Medicare benefits be made to me or on my behalf to ARNE CHIROPRACTIC AND WELLNESS CENTER, P.C. for any services furnished me by that physician/clinic/supervisor.*

Date: ___/___/___ **Signed:** _____