

Date _____

Patient Information

(Please Print)

Name _____ Nickname _____

Phone (____) _____ - _____ Cell (____) _____ - _____ Email _____

Address _____ City _____ State _____ ZIP _____

Sex (circle) Male Female DOB ____/____/____ Age _____ SSN ____-____-____

Marital Status _____ Spouse's Name _____ No. of children _____

Individual Responsible for Account (If different from patient) _____

Primary Care Physician _____ Referred by _____

Major Complaint _____

Employer/Position _____ Phone (____) _____ - _____ Ext _____

Address _____ City _____ State _____ ZIP _____

Please present your insurance card to the front desk Ins. Co. _____

Insured (leave blank if same) _____ Employer _____

Address _____ City _____ State _____ ZIP _____

Phone (____) _____ - _____ DOB ____/____/____ SSN ____-____-____

Assignment of Benefits, Authorization for Release of Information, and Consent

- 1) **Assignment of Benefits:** I hereby direct my insurance carrier(s) or attorney to pay by check made and mailed directly to: **Post Clinic of Chiropractic, PC, 4141 NW Expwy Ste 180, Oklahoma City, OK 73116**
- 2) I also understand that I am personally responsible and agree to pay, in a current manner, any balance due after payment or non-payment by my insurance carrier(s) or attorney.
- 3) **Authorization for Release of Information:** I hereby authorize the release of any pertinent information to any doctor, insurance company, adjuster, or attorney involved in this claim.
- 4) A photocopy of this "Assignment of Benefits" and "Authorization for Release of Information" shall be considered as effective and valid as the original.
- 5) **Consent:** I give permission to the doctor and his staff to administer treatment and perform such procedures as deemed necessary in the diagnosis and treatment of named patient.

Patient/Guardian Signature _____

I have read and agree to the above statements