

LionsGate Chiropractic Confidential Intake Form

Date: _____

Accident/Injury: YES NO

Patient Information:

Full Name: _____ Date of Birth: _____

Marital Status: Single ___ Married ___ Widowed ___ Male Female Other

Address: _____ APT# _____ City: _____

State: _____ Zip Code: _____ Phone: _____ Home or Cell circle one

Email: _____ Appointment Reminders: Y or N circle one

Email Reminder Text Reminder Both Cell Carrier: _____

Employer's Name: _____ Occupation: _____

Work Location: city _____ state _____ Work Phone: _____

Date Symptoms Began: _____ How did you hear about us: _____

**Emergency Contact: _____ Phone: _____

Insurance Information:

Relationship to Insured: Self ___ Spouse ___ Child ___ Other ___

Insured's Name: same as above _____ Date of Birth: _____

Primary Insurance Company: _____

Claims Mailing Address: _____ Suite: _____

City: _____ State: ___ Zip Code: _____ Phone: _____

Policy/Member ID#: _____ Group# _____

Secondary Insurance Company: _____

Claims Mailing Address: _____ Suite: _____

City: _____ State: ___ Zip Code: _____ Phone: _____

Policy/Member ID#: _____ Group# _____

Staff Only: Copy of Insurance Card/s and State Issued ID/DL provided YES ___ NO ___

Employee Initials _____

LionsGate Chiropractic Authorizations & Financial Agreement

Financial Responsibility

By signing this agreement, you acknowledge that you are financially responsible for all services provided by Lionsgate Chiropractic. This includes charges for treatments, exams, and any other services rendered, regardless of insurance coverage.

1. Insurance Billing and Coverage

- **Verification of Benefits:** Our office will assist in verifying insurance benefits; however, verification is not a guarantee of coverage. You are ultimately responsible for confirming the benefits and coverage with your insurance provider.
- **Assignment of Benefits:** I authorize release of any medical information necessary to process claim/s and request payment of insurance benefits either to myself and/or the party who accepts assignment. I authorize medical benefit from third parties for benefits submitted for my claim/s to be paid directly to this office and any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.
- I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.
- **Non-Covered Services:** I understand that some services may not be covered by my insurance, and I am responsible for these charges.

2. Payment Policies

- **Co-pays and Deductibles:** Co-pays, deductibles, and any known non-covered charges are due at the time of service.
- **Self-Pay:** Patients without insurance coverage or those opting for self-pay agree to pay the full amount at the time of each visit, unless other arrangements are made.
- **Payment Methods:** We accept cash, checks, and major credit/debit cards.

3. Missed Appointments and Late Cancellations

If you need to cancel or reschedule an appointment, please notify us at least 24 hours in advance. Failure to do so may result in a missed appointment fee. This fee is the responsibility of the patient and cannot be billed to insurance.

4. Collections and Outstanding Balances

Any balance unpaid after 90 days from the date of service is considered delinquent. Should your account become delinquent, Lionsgate Chiropractic reserves the right to use a collections agency, and you will be responsible for all collection fees, attorney fees, and other associated costs.

5. Returned Checks

A fee will be applied to any returned checks. If payment issues persist, we reserve the right to require cash or credit card payments.

6. Refund Policy

Refunds are available for pre-paid, unused services. No refunds will be provided for services already rendered.

7. Agreement and Consent

By signing below, I acknowledge that I have read, understood, and agree to the terms of this Patient Financial Agreement. I accept financial responsibility for all services provided by Lionsgate Chiropractic.

Patient Name: (print) _____ **Date:** _____

Patient Signature: (parent or guardian) _____ **Employee Initials** _____