

**PATIENT INFORMATION**

TODAY'S DATE: \_\_\_\_\_

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
Last name First name MI

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Email: \_\_\_\_\_

Spouse or Parent(s) Name: \_\_\_\_\_

In case of emergency, please notify: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**INSURANCE INFORMATION: PLEASE PROVIDE YOUR INSURANCE CARD AS WELL AS A VALID PHOTO ID**

**INSURED PARTY NAME**

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

**PATIENT EMPLOYER INFORMATION**

Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**FINANCIALLY RESPONSIBLE PARTY (if other than insured)**

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address (if different from patient's): \_\_\_\_\_ Home Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. Furthermore, I understand that CAROLINA CHIROPRACTIC, DR. MARC S. GOTTLIEB, P.C. 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 CAROLINA CHIROPRACTIC, DR. MARC S. GOTTLIEB, P.C. will be credited to my account upon receipt. I also give CAROLINA CHIROPRACTIC, DR. MARC S. GOTTLIEB, P.C. power of attorney to endorse checks made out to me, to be credited to my account. 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 medical/professional services rendered to me will be immediately due and payable. This assignment and release shall be irrevocable for the full extent of my treatment by CAROLINA CHIROPRACTIC, DR. MARC S. GOTTLIEB, P.C. and until such time that my medical/professional expenses incurred have been paid in full. In the event that my account balance becomes overdue and it is necessary to refer it to a collection agency, I will be responsible for paying all costs of collection including, but not limited to, reasonable attorney fees and maximum interest permitted by law. Interest of 1.5% per month of the unpaid balance will be assessed on all overdue accounts. A copy of this assignment and release shall be considered as effective and valid as the original.

Patient/Responsible Party Signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_