# PATIENT CONFIDENTIAL INFORMATION

Date _____ Case # _____

First Name _____ M.I. _____ Last Name _____

Address _____ City _____ St _____ Zip _____

Social Security #_____ ☐ Married ☐Single ☐Divorced ☐Widowed ☐Separated

☐Male ☐Female Date of Birth _____ Age _____ Drivers License # _____

Home Phone _____ Cell Phone _____ Work Phone _____

E-Mail Address _____

Employer Name _____ Phone _____ Job Title _____

Spouses Name _____ Employer _____

Do you have insurance? ☐No ☐Yes Was this an Auto Accident or Work Injury? ☐No ☐Yes (If yes, please list auto insurance information)

Name _____ Phone _____ Policy # _____

**In compliance with HIPPA Regulations, I have received a copy of Simpson Spine & Sport's Privacy Policy.** _____
Initial Here

I understand and agree that health and accidental insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that:

- ☒ This office will prepare any necessary reports and forms to assist me in making collection from the insurance company.
- ☒ There may be a charge for some reports.
- ☒ Any amount authorized to be paid directly to this office will be credited to my account upon receipt.

In consideration of you providing care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical conditional, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney, out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole, or in part, upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me, or to you, for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against such a company and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. It is understood, however, that until all reasonable efforts have been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from attempts and efforts to collect amounts owed directly by me. **I understand that whatever amounts you do not collect from insurance companies, whether it be all or part of what is due, I personally owe you**.
4. In addition to the above, I hereby waive the statute of limitations on collection and or recovery in the state of Oregon. I understand that I may be assessed a fee of up to $100 if it becomes necessary to refer my account to an outside collections agency.
5. I further agree that this Authorization and Assignment is irrevocable until all monies owed Simpson Spine and Sport Chiropractic Clinic are paid in full.

I authorize the release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or the party who accepts assignment below.

I authorize any medical benefits from my insurance company to be paid directly to Simpson Spine and Sport Chiropractic Clinic for any services rendered to me.

**Patient Signature** _____ **Date** _____ Staff Signature _____ Date _____

**CONSENT FOR TREATMENT OF A MINOR CHILD**

I hereby authorize Dr. Kenneth R. Simpson, D.C., and whomever he may designate to administer Chiropractic care as deemed necessary.

_____, my _____. _____

*Name of Minor* *Relationship* *Parent Signature* *Date*