IS YOUR CURRENT CONDITION DUE TO AN ACCIDENT? ___Yes ___No Date of Accident: ___/___/_____
TYPE OF ACCIDENT: ___Auto ____Work ____Other Describe:_____

Please fill out respective section depending on accident type

WORK ACCIDENT INFORMATION

Work Comp. Claim #:_____

Insurance Company:_____

Adjuster:_____

Phone #: (____)____-_____

Date Filed: ___/___/_____

If you have an attorney, may we contact him/her regarding your care?
Name:_____ Phone #:_____

AUTO ACCIDENT INFORMATION

Has Fault Been Established? __Yes __No __Yours __Other
If accident is your fault, please fill in Your Auto Insurance Section, if not, please fill out both Yours AND Other's Insurance Section!

Your Auto Insurance Company:_____
Adjuster:_____ Phone #:_____
Claim #:_____

Other's Insurance Company:_____
Adjuster:_____ Phone #:_____
Claim #:_____
Policy Holder:_____

If you have an attorney, may we contact him/her regarding your care?

MISSED APPOINTMENTS:
Unless cancelled **at least 24 hours** in advance, we reserve the right to charge a **$30.00** missed appointment fee. We have voicemail available 24 hours a day, 7 days a week should you need to cancel during non-office hours. We may have patients waiting for an appointment on a cancellation list; your courtesy of a phone call allows us to schedule them. This charge is not covered by or billed to your insurance. Your signature indicates that you understand our policy.
Signature_____ **Date**_____

SUPPLIES AND EQUIPMENT:
I agree to pay for physical therapy supplies, orthoses , braces or equipment in full on the date of service. If these items are specifically
covered under my health insurance, I understand that I will only be reimbursed the amount of money paid to ClearWater Chiropractic by my insurance. I understand that ClearWater Chiropractic does not have a contract with my insurance company to provide supplies, orthoses, braces, equipment or any durable medical goods.
Signature_____ **Date**_____

RELEASE OF INFORMATION:
I do/ do not (please circle one) authorize any other healthcare providers to release my medical records, x-rays, or reports to ClearWater Chiropractic for the purpose of obtaining medical information pertaining to my treatment.
Signature_____ **Date**_____

INSURANCE:
I hereby assign payment directly to ClearWater Chiropractic, who represents this clinic to payor groups for the basic benefits, as well as major medical benefits herein specified and otherwise payable to me, but not to exceed the regular charges for this treatment period. I understand that if my injury is due to a motor vehicle accident and the medical benefits are exhausted as such that Financial responsibility reverts to my health insurance. I am financially responsible for any applicable deductibles or co-pays. I also understand that I am financially responsible for any charges not covered by this assignment; including denials due to failed attempts to preauthorize care. Patients may incur a $10 "claims resubmission" charge should a properly submitted claim be denied, lost, or incorrectly processed by your insurance. I understand that I will be held responsible for any costs incurred regarding collection of payment for services rendered. I will update billing information as soon as any changes occur in my insurance coverage, address or contact information.
Signature_____ **Date**_____

ACKNOWLEDGEMENT OF OUR PRIVACY PRACTICES
By signing below, I acknowledge that I have reviewed a copy of the Notice of Privacy Practices and have, therefore, been advised of how health information about me may be used and disclosed by ClearWater Chiropractic and how I may obtain access to