SIGOURNEY CHIROPRACTIC AND WELLNESS

DR. KODEY SALOW
100 E. WASHINGTON ST
SIGOURNEY, IA 52591

Patient Information

First Name ____________________________ Middle Initial ________ Last Name __________________________

Address ____

City____ State________________ Zip Code ___________________

Primary Phone: ___________________________ Email: _______________________________________

Date of Birth [/ /] Gender: ❑Male ❑ Female ❑ Other

Marital Status: ❑Single ❑Married ❑Widowed ❑Divorced

Emergency Contact (Name and Number) ____

Employment Status: ❑ Employed ❑Retired ❑Student

Place of Employment ____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Privacy Statement (HIPAA)

I consent to the release of my personal health information by Sigourney Chiropractic and Wellness for use in treatment, payment, or health care operations. I have been given the opportunity to review the privacy notice describing the policy and procedures of Sigourney Chiropractic and Wellness regarding the release of my personal health information. I understand that this consent shall remain in force and effect unless it is revoked in writing.

_______________________________________ ___________________________

Signature Date

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Assignment and Release

Sigourney Chiropractic and Wellness is authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster to process any claim for reimbursement of charges incurred. I assign directly to Sigourney Chiropractic and Wellness all medical benefits otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I agree that this authorization and release is irrevocable and ongoing until all monies owed are paid in full and will be in continual effect until revoked by both parties.

Office Policy

We believe that a clear understanding of our office policies will allow us to concentrate on the big issue - REGAINING AND MAINTAINING YOUR HEALTH.

We attempt to honor all appointments at the scheduled time. If you are late, you may have to wait for the next available appointment. If you are unable to keep an appointment, please call immediately to reschedule your visit. It is to your benefit to make up a missed appointment within 7 days of any cancellation. Regardless of how many appointments you have in a week, please note that it is the frequency of the visits that counts, not the days.

All payments are expected at the time services are rendered. Balances will not exceed $170.00 at any one time. Balances over 30 days will be subject to 1.5% charge. Returned checks will be subject to a $20 insufficient funds fee. You are ultimately responsible for all charges.

____ ________________________
Signature Date