Barrington Chiropractic LLC
3823 Spenard Road
Anchorage, AK 99517

PLEASE PRINT NEATLY

TODAY'S DATE:

SECTION A
PATIENT DEMOGRAPHICS

LAST NAME:		HOME PHONE # : ( )
FIRST NAME:	M.I.:	WORK PHONE # : ( )
PHYSICAL STREET ADDRESS:		CELL PHONE # : ( )
MAILING ADDRESS:		DATE OF BIRTH: / /
CITY:	STATE:	SOCIAL SECURITY # - -
ZIP CODE:		MARITAL STATUS: MARRIED SINGLE WIDOWED DIVORCED
EMPLOYED: YES / NO / RETIRED	SEX: M ☐ F ☐	REFFERED BY: PHYSICIAN REFFERAL : YES ☐
EMPLOYER:		FIRST NAME:
JOB TITLE:		LAST NAME:
E-MAIL ADDRESS:		REF. PHYSICIAN PHONE #: ( )

REASON FOR TODAY'S VISIT (YOUR MAJOR COMPLAINT)

IS TODAY'S VISIT DUE TO A **WORKERS' COMPENSATION INJURY**? YES ☐ NO ☐
If yes, please complete all questions in section D on Page 2 of this document.

Is today's visit due to a **MOTOR VEHICLE ACCIDENT** or a **Personal Injury** caused by a third party? YES ☐ NO ☐
If yes, please complete all questions in section E on Page 2 of this document.

SECTION B
BILLING INFORMATION (Please supply our receptionist with all cards so copies can be made.)

PRIMARY HEALTH INSURANCE INFORMATION:	**SECONDARY HEALTH INSURANCE INFROMATION:**
Insurance Name:	Insurance Name:
Street Address:	Street Address:
City, State, Zip:	City, State, Zip:
Phone #: ( )	Phone #: ( )
Group Name or #:	Group Name or #:
Insured Party #:	Insured Party #:
Policy Date Effective:	Policy Date Effective:
Who's Insurance is this? Self ☐ Spouse ☐ Parent ☐	Who's Insurance is this? Self ☐ Spouse ☐ Parent ☐
If Spouse or Parent, their name:	If Spouse or Parent, their name:
Insured's Date of Birth: (**Required**) / /	Insured's Date of Birth: (**Required**) / /
Insured's Employer:	Insured's Employer:
Is this an employer insurance plan?: YES ☐ NO ☐	Is this an employer insurance plan?: YES ☐ NO ☐

** If you have 3rd Health Insurance Company, Please fill out Section C on Page 2.**

EMERGENCY CONTACT NAME:	
EMERGENCY PHONE #:	RELATION TO YOU:

ATTENTION PATIENTS: ALL DEDUCTIBLE AND COPAY AMOUNTS ARE DUE AT THE TIME OF SERVICE
***** WE ACCEPT VISA, MASTER CARD, AMER EXPRESS, DISCOVER, PERSONAL CHECKS AND CASH*****

Barrington
CHIROPRACTIC LLC

Edward J. Barrington, DC/DABCN ● *Board Certified Chiropractic Neurologist*
3823 Spenard Rd. Anchorage Alaska 99517
(907) 677-1600 *Fax* (907) 677-2779

PLEASE READ CAREFULLY

It is customary for payment to be made at the time services are rendered, unless other arrangements have been made in advance with the office manager.

Name of Person Responsible for Payment _____

Are you insured? _____Yes _____No

Name of Policy Holder _____

Insurance Company_____

Insured's DOB _____

ID# _____ GRP# _____

_____By initialing I acknowledge receipt of Barrington Chiropractic, LLC Notice of Privacy Practices (NPP) and further more that I may request a paper copy of NPP from Barrington Chiropractic at any time.

In exchange for Barrington Chiropractic (clinic) forbearance from collecting all accounts owed by me for services rendered at the time of the provision service I hereby assign my rights to the clinic as follows: I understand and agree that health and accident insurance policies are an arrangement between an insurance company or carrier and myself. Furthermore, I understand that the clinic will prepare any necessary reports and forms provided by me to assist me, or my legal representative, in making collection from the insurance company or carrier. I hereby specifically authorize the release of any information concerning me to my insurance carriers, insurance carriers of persons or entities responsible for my injuries, my employer, and claim adjusters responsible for claims filed by administrative agencies, the Alaska Worker's Compensation Board, my attorneys and me. To the extent of my unpaid bill to the clinic, I hereby irrevocably assign to said clinic on behalf of myself, my heirs and beneficiaries any interest that I might have now or in the future to any case of action or claim, whether legal or administrative, and direst my legal representative that at the time of the final judgment and final disposition or settlement this assignment shall have priority over all others not entitled by law to superior priority.

I specifically request that any amount authorized to be paid to me by an insurance company; employer or legal representative shall be paid directly to Barrington Chiropractic, and will be credited to my account upon receipt. If the payment is insufficient to pay for all of my indebtedness, I will remain liable to Barrington Chiropractic for the balance, including any finance and collection charges. I also understand that any unpaid balance by me after 30 days will be subject to the current rate of interest and understand the current rate may change from year to year.

I clearly understand and agree that all services that are rendered to me, whether I have health or accident insurance coverage or not, are charged directly to me, and that I am personally responsible for payment and , unless arrangement are otherwise made, said payments are immediately due and payable at the time services are rendered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. In such an event, I agree that this assignment will remain in effect until all sums I owe to the clinic are fully paid.

Patient's signature_____ Date_____

Social Security #:_____ Driver's License #:_____

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Chiropractic Treatment/Diagnostic Consent Form

By my signature below, I _____, verify and represent to Dr. Edward J. Barrington, D.C./D.A.B.C.N. d.b.a. Barrington Chiropractic:

1) That I have consented to the performance of Chiropractic Treatment/Diagnostic Studies as they have explained the proposed treatment to me, and;
2) That prior to giving my consent to this proposed treatment, the Chiropractic Physician has discussed with me, and offered me an opportunity to ask questions I had regarding each of the following matters:
    a. The risks and complications involved in the procedure proposed;
    b. The risks and complications resulting from not undergoing the proposed procedure;
    c. The probability of a successful outcome from the proposed procedure;
    d. The expected benefits resulting from the proposed procedure and;
    e. The alternative treatment available to me and the risks and benefits associated with each alternative, and;
3) That prior to giving my consent to this procedure, the Chiropractic Physician answered all of my questions, if any, I had concerning the matters listed above and provided me with all information that I desired regarding the proposed procedure, and;
4) That the Chiropractic Physician also explained to me and I understand that while I am under care, risks and complications may arise during the course of the proposed procedure which may not have been foreseen at the time I gave my consent for the proposed procedure. Therefore, I further verify that I have agreed with the Chiropractic Physician that if such unforeseen risks or complications should arise, I have also consented to further treatment by the Chiropractic Physician and/or by a Physician as they deem in my best interest under the circumstances.

_____ _____
Date Signature of patient/guardian/representative

_____ _____
Date Signature of Doctor