Shoff Chiropractic

2621 East Lake Street Minneapolis, MN 55406

(612) 722-8554

PATIENT INFORMATION FORM

NAME_____SSN_____DATE OF BIRTH_____

ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE (___) _____CELL PHONE (_ __) _____SEX_____MARITAL STAUS_____

E-MAIL_____

PATIENT EMPLOYER NAME_____WORK # (__ _) _____

PERSON RESP. FOR PAYMENT ON ACCOUNT_____ SSN_____

EMERGENCY CONTACT_____PH# (_ __) _____

IS SERVICE ACCIDENT RELATED? YES OR NO IF YES, ACCIDENT DATE_____

WHAT KIND OF ACCIDENT IS THIS? WORK COMP, AUTO, OR PERSONAL INJURY? (CIRCLE ONE)

PRIMARY INSURANCE NAME AND ADDRESS:

PRIMARY INSURED NAME_____ PRIMARY INSURED SSN_____

RELATION TO PRIMARY INSURED_____ GROUP#_____

PRIMARY INSURED DATE OF BIRTH_____PRIMARY INSURED EMPLOYER_____

SECONDARY INSURED NAME_____GROUP #_____

SECONDARY INSURED DATE OF BIRTH_____SECONDARY INSURED EMPLOYER_____

I authorize the release of any medical or other information necessary to process this claim. I also request payment of medical benefits from either a government or non- government source to Michael J. Shoff. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered and I understand that I will be charged a 1.5% monthly or (18% annual percentage rate) with a minimum monthly fee of $1.00 on any non-contract insurance balances over 30 days. I further understand that I will be legally responsible for all collection costs involved with the collection on this account including all court costs, reasonable attorney fees and all other expenses incurred with collection if I default on this agreement. While Michael J. Shoff will aide in the processing of my non-contract insurance claim, I understand that if my insurance does not pay within 60 days, my account will be determined as self- pay and due in full by myself. I certify this information is true and correct to the best of my knowledge.

SIGNATURE_____DATE_____